

11540

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ a. STATE <u>DISTRICT of Columbia</u> b. COUNTY <u>47X-3</u>	
b. CITY OR TOWN (If outside corporate limits, write "RURAL and give nearest town") <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON DISTRICT OF COLUMBIA</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u> 3700		d. STREET ADDRESS <u>MASS. AVE. NW WASHINGTON APT. 31 ALBAN TOWERS.</u>	
3. NAME OF DECEASED (Type or print) <u>Marie Lillian</u> First Middle Last		4. DATE OF DEATH Month <u>10</u> Day <u>28</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 18, 1882</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Switzerland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Solomon Richard Frey</u>		14. MOTHER'S MAIDEN NAME <u>Rosalie Weber</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> <u>527.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic pulmonary fibrosis</u> (c) <u>emphysema</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hr</u> <u>yes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arteriosclerotic cardiovascular disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>25 Oct, 1959</u> to <u>28 Oct, 1959</u> that I last saw the deceased alive on <u>27 Oct, 1959</u> and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Horace W. Bernton, M.D.</u>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Horace W. Bernton, M.D.</u>		<u>10511 Summit Ave., Kensington, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Removal</u>		22b. DATE THEREOF <u>10-30-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery Suitland, Prince Georges Co</u>		22d. LOCATION (City, town, or county) (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jos. Hawler's Sons Inc. 1756 Pa. Ave. NW</u>		24a. REC'D BY REGISTRAR <u>OCT 30 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

10 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

10 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11440

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CERTIFICATE OF DEATH

11486

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Md.</u>		c. LENGTH OF STAY IN 1b <u>87 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ranier Sanatorium + Hospital</u>		d. STREET ADDRESS <u>3119 - 38th Street NW</u>	
3. NAME OF DECEASED (Type or print) First <u>Isabel</u> Middle <u>Addison</u> Last <u>Addison</u>		4. DATE OF DEATH Month <u>10</u> / Day <u>31</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/25/1875</u>
9. AGE (In years lost birthday) <u>84</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U. S. Govt. Ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Clerical</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Watkins Addison, Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Dodge</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>W. W. 1</u>	
17. INFORMANT <u>Hospital Record</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u> <u>30 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Lobar pneumonia</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June</u> , 19 <u>59</u> , to <u>10/31</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10/29</u> , 19 <u>59</u> , and that death occurred at <u>9:50</u> A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1728 Mass Ave N.W.</u> DATE SIGNED <u> </u>			
ACTUAL SIGNATURE <u>John W. Latimer, Jr.</u> M.D.		PHYSICIAN'S NAME (Type) <u>John W. Latimer, Jr.</u> <u>Washington D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/3/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph F. Burckli Son</u>		24a. REGISTERED BY REGISTRAR <u>3034 M. St. N. W.</u> DATE <u>NOV 3 59</u>	24b. REGISTRAR'S SIGNATURE <u> </u>

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN lb 6 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens		d. STREET ADDRESS 2006 Columbia Rd., N. W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELLA Middle V. Last ALLNUTT		4. DATE OF DEATH Month Oct. Day 31 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 21, 1873
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months 8 Days 10 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U. S.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Charles Thomas		14. MOTHER'S MAIDEN NAME Annie Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
INFORMANT Daughter Mrs. Thomas Perry		3510 Raymoor Rd. Kensington, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 334x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Rt. hemiplegia DUE TO (c) Cerebral arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 7 yrs. 20 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1948 , 19 59 , to 31 Oct. 1959 , that I last saw the deceased alive on 31 Oct. 1959 , and that death occurred at 5:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1726 M Street, N. W. DATE SIGNED ACTUAL SIGNATURE Charles W. Thompson M.D. PHYSICIAN'S NAME (Type) CHARLES W. THOMPSON Washington, D. C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-2-59	
22c. NAME OF CEMETERY OR CREMATORY Monocacy Cemetery		22d. LOCATION (City, town, or county) (State) Beallsville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		24a. REC'D BY REGISTRAR DATE NOV 4 '59	
ADDRESS Bethesda, Md.		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	

CERTIFICATE OF DEATH

11542

Washington

City of Columbia

6 years

Washington

Admission for patients

2000 Columbia Ave., N. W.

V. ALBERT

Oct. 22

Feb. 21, 1900

1900

Married

Housewife

Annie Jones

Charles Thomas

Mr. Thomas Taylor

Wife

11542

11542

11542

11542

11542

11542

11542

11542

11542

11542

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11543

CERTIFICATE OF DEATH

Reg. Dist. No.

11488

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. LENGTH OF STAY IN 1b 35 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAYTONSVILLE			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) MARY FRANCES ALLNUTT		First Middle Last		4. DATE OF DEATH OCTOBER 20 19 59		Month Day Year	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/8/90	9. AGE (In years lost birthday) yrs. 69	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy Dept. Bureau Of Docks				10b. KIND OF BUSINESS OR INDUSTRY MARYLAND		11. BIRTHPLACE (State or foreign country) USA	
13. FATHER'S NAME WILLIAM DOUGLAS BELL				14. MOTHER'S MAIDEN NAME IDA FIDELIA WARFIELD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 218 38 6131			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Leukemia, Granulocytic 204.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO				INTERVAL BETWEEN ONSET AND DEATH 5 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-15 , 19 59 , to 10-20 , 19 59 , that I last saw the deceased alive on 10-20 , 19 59 , and that death occurred at 11:30A , from the causes and on the date stated above.							
ACTUAL SIGNATURE Jack Schumacher M.D.				ADDRESS (Street, city or town, state) 10-20-59			
PHYSICIAN'S NAME (Type) J. SCHUMACHER, M. D.				GAIHERSBURG, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 22 59		22c. NAME OF CEMETERY OR CREMATORY Laytonsville		22d. LOCATION (City, town, or county) (State) Laytonsville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Roy W Barber				ADDRESS Laytonsville, Md.		24a. REC'D BY REGISTRAR Oct 26 59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11182

CENTINATE CHURCH

MONTGOMERY

MARYLAND

WASHING

HEATONARY

LAYTONVILLE

35 DAYS

OTHER

MONTGOMERY LAYTON GENERAL HOSPITAL

DECEMBER 20 1930

ALLIANCE

FRANCIS

MAX

1930

WATER

USA

MARYLAND

U.S. Navy Dept. Bureau of Books

13A FIDELIA WATKINS

WILLIAM HENNING

35 35 35

ONE 1 30

HOSPITAL RECORDS

Handwritten signature

WATKINS, MARYLAND

WATKINS, MARYLAND

LAYTONVILLE

35 35 35

LAYTONVILLE, MD.

11544

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 27 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Michigan b. COUNTY Detroit c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 59X-3 d. STREET ADDRESS 17159 Van Buren Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Frances Mary ANDERSON				4. DATE OF DEATH Month Day Year October 7 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-13-05	
9. AGE (In years last birthday) 53		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Colorado	
13. FATHER'S NAME Harley FRINK				14. MOTHER'S MAIDEN NAME Madge RUSSELL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. (Son) Russell Anderson		17. INFORMANT Naval Research Institute Beth. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma toxic 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of R. breast DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Livonia, Wayne, Michigan				20g. (County) Livonia, Wayne, Michigan		20h. (State) Livonia, Wayne, Michigan	
21. I certify that I attended the deceased from 10 Sept , 19 59 to 7 October , 19 59 that I last saw the deceased alive on 7 October , 19 59 , and that death occurred at 8:35 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md. DATE SIGNED _____ ACTUAL SIGNATURE C.W. Bramlett M.D. U.S. Naval Hospital, Bethesda Md. PHYSICIAN'S NAME (Type) C.W. BRAMLETT LT MC USN U.S. Naval Hospital, Bethesda Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 10-10-59		22c. NAME OF CEMETERY OR CREMATORY Woodmere Crematory		22d. LOCATION (City, town, or county) (State) Livonia, Wayne, Michigan	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey				24a. REC'D BY REGISTRAR 13 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

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CENTRAL OF DENIA

Michigan

Detroit

TV days

Bedford (Herald)

U.S. Naval Hospital, Bethesda Md.

1715 Van Buren Street

ANDREWS

MARY

Frances

12-13-52

White

Tennis

Colorado

Home

Horseshoe

MADGE RUSSELL

Harley RINK

Naval Hospital

(Son) Russell Anderson

No

10 days 10 October 52

10 October

U.S. Naval Hospital, Bethesda Md.

U.S. Naval Hospital, Bethesda Md.

C.W. FRANKLIN LT MC USN

10-10-52 Woodmen Cemetery, Divonia, Wayne, Michigan

R.A. Hughes 1851 Wisconsin Ave. Bethesda Md.

CERTIFICATE OF DEATH

Reg. Dist. No. 215

11545

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 208 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Egg Harbor City d. STREET ADDRESS Rd4 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Elizabeth Dejean ANNER				4. DATE OF DEATH Month Day Year October 9 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-21-19	
9. AGE (In years lost birthday) 39 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		11. BIRTHPLACE (State or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Henry ANNER				14. MOTHER'S MAIDEN NAME Leisla SINGLETON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) Yes WW II				16. SOCIAL SECURITY NO. 486 22 5656			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Hemorrhages 292.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Aplastic Anemia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 292.4				INTERVAL BETWEEN ONSET AND DEATH 24 hrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2 Feb 1959 to 9 October 1959 that I last saw the deceased alive on 9 October 1959 , and that death occurred at 4:04 AM from the causes and on the date stated above.							
ACTUAL SIGNATURE R. G. Muth				ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md.			
PHYSICIAN'S NAME (Type) R. G. MUTH LT MC USN				U.S. Naval Hospital, Bethesda Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-10-59		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Memorial		22d. LOCATION (City, town, or county) (State) Prince George Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE S. H. HINES				ADDRESS 2901 14th Street N.W. Washington D.C. 3 '59		24b. REGISTRAR'S SIGNATURE Arthur P. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

15-51-99

. 2 .

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11491

11546

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN TB <u>5 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>313 North West Dr</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u> d. STREET ADDRESS <u>313 North West Dr</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Joseph Aloysius Ashie</u> First Middle Last 4. DATE OF DEATH <u>Oct 19 1959</u> Month Day Year				5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>12-14-1893</u> 9. AGE (In years last birthday) <u>65</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>N.Y. City</u> 11. BIRTHPLACE (State or foreign country) <u>N.Y. City</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>				13. FATHER'S NAME <u>Abraham Ashie</u> 14. MOTHER'S MAIDEN NAME <u>SADA ASSAD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW.I</u> 16. SOCIAL SECURITY NO. <u>NEW.I</u> 17. INFORMANT <u>June Ashie (wife)</u> Address <u>Stun 2</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10-19-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-22-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>		22d. LOCATION (City, town, or county) <u>ARLINGTON</u> (State) <u>VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. J. Collins</u> ADDRESS <u>WASH. D. C. 3821 14TH. ST. N.W.</u>				24a. REC'D BY REGISTRAR <u>OCT 23 '59</u> DATE _____		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

100

11547

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 42 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47 X-3 d. STREET ADDRESS 3133 Conn. Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Frank (n) BALDWIN				4. DATE OF DEATH Month Day Year October 19 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-19-1880	
9. AGE (In years lost birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy				10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) New Jersey	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Henry BALDWIN				14. MOTHER'S MAIDEN NAME Julia BORREES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWI&II				16. SOCIAL SECURITY NO. Informant Hospital records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral arteriosclerosis 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Esophageal diverticulum							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 7 September 59 to 19 October 19 59 , and that I last saw the deceased alive on 19 October 19 59 , and that death occurred at 7:07 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Francis J. Linch				ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md. DATE SIGNED 10-14-59			
PHYSICIAN'S NAME (Type) U.S. Naval Hospital, Bethesda Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-22-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawlers ADDRESS 1756 Penn. Avenue N.W. Washington, D.C.				24a. REC'D BY REGISTRAR 667-8-59		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. Naval Hospital, Bethesda Md.
U.S. Naval Hospital, Bethesda Md.

10-22-52 Arlington National
Washington, D.C.

October 1952

October 1952

October 1952

Yes

Henry E. ELLIOTT

U.S. Navy

White

Frank

U.S. Naval Hospital, Bethesda Md.

2 days

Washington

U.S. Navy

U.S. Navy

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11493

11548

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Echo Heights c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Glen Echo Heights d. STREET ADDRESS 12 Wyoming Court e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Coy Middle T Last Barefoot		4. DATE OF DEATH Month Oct Day 17 Year 1959	
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 11, 1890
9. AGE (In years lost birthday) 69 yrs.		10. IF UNDER 1 YEAR Months 6 Days 6 Hours 0 Min. 0	11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab Driver		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILEY T BAREFOOT		14. MOTHER'S MAIDEN NAME Mary Tart	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT Mrs Anna Barefoot Address 2 Wyoming & Glen Echo	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 585x Intestinal obstruction DUE TO (b) Emphysema of gall bladder & pneumonia DUE TO (c) 10 Days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. Oct 17 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-21-59 , 19 59 , to 10-17 , 19 59 , that I last saw the deceased alive on 10-17 , 19 59 , and that death occurred at 2:55 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE John C. Murphy M.D.		PHYSICIAN'S NAME (Type) John C. Murphy 4630 Montgomery Ave., Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-21-59	
22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		22d. LOCATION (City, town, or county) (State) ROCKVILLE MD	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co ADDRESS 3072 M-St NW Wash, D.C.		24a. REC'D BY REGISTRAR OCT 20 '59 DATE	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

MEDICAL CERTIFICATION

11 100

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

CERTIFICATE OF DEATH

1922

[Faint, mostly illegible text, likely a form or record, possibly containing names and dates.]

11 100

11549

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN lb 101 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY Charleston c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 85X-3 d. STREET ADDRESS 902 Morris Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First Orange Middle Lee Last Barksdale		4. DATE OF DEATH Month October Day 26 Year 1959		5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 9, 1884		9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Miner				10b. KIND OF BUSINESS OR INDUSTRY Coal Mining				11. BIRTHPLACE (State or foreign country) North Carolina				12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Isaac Barksdale				14. MOTHER'S MAIDEN NAME Doshie A. Lee				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 232-28-5601				INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of stomach with metastases to liver, retroperitoneal tissue, and vertebrae; and carcinoma of right maxillary antrum with metastases to meninges and middle ears. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 151X (c) XXXX INTERVAL BETWEEN ONSET AND DEATH months 1 year																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)																			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 17 , 19 59 , to October 26 , 19 59 that I last saw the deceased alive on October 26 , 19 59 , and that death occurred at 8:05 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 10-26-59 National Institutes of Health Bethesda 14, Maryland																			
ACTUAL SIGNATURE Edward D. McLaughlin				M.D. The Clinical Center				DATE SIGNED 10-26-59				PHYSICIAN'S NAME (Type) Edward D. McLaughlin, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 10/29/59				22c. NAME OF CEMETERY OR CREMATORY Spring Hill				22d. LOCATION (City, town, or county) (State) Charleston, W. Va.							
23. FUNERAL DIRECTOR'S SIGNATURE For: Brooks & Allen Funeral Home				ADDRESS 1200 Fla. Ave. N.W. Wn.D.C.				24a. REC'D BY REGISTRAR OCT 29 '59				24b. REGISTRAR'S SIGNATURE Arthur S. House							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

West Virginia

Montgomery

Chapman

101 days

Hepatitis

902 Morris Street

The Clinical Center, Bethesda, Md.

Hepatitis

100

Orange

XX

June 2, 1961

Hepatitis

Hepatitis

North Carolina

Coal Mining

Coal Miner

Hepatitis

Hepatitis

The Medical Record

332-28-2601 The Clinical Center, Bethesda, Md.

Examination of serum with reference to liver
retroperitoneal disease, and
examination of liver biopsy specimen with
reference to hepatitis and cirrhosis.

October 25, 59

July 17

October 26, 59

The Clinical Center
National Institutes of Health
Bethesda, Md.

Howard D. Johnson, M.D.

CERTIFICATE OF DEATH

Reg. Dist. No.

11550

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>18 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EUGENE S. BARRY</u>		4. DATE OF DEATH Month Day Year <u>10 6 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-11-1879</u>
9. AGE (In years last birthday) <u>80 yrs.</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TANNER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TANNING</u>	
11. BIRTHPLACE (State or foreign country) <u>MASS.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>EUGENE BARRY</u>		14. MOTHER'S MAIDEN NAME <u>LUCY WYMAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>018-10-5792</u>	
17. INFORMANT <u>JANE BALSLEY</u>		Address <u>3316 McCOMAS AVE. KENSINGTON, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>4222</u> IMMEDIATE CAUSE (a) <u>cerebral thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>cardiovascular disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>colostomy, release of intestinal obstruction</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>10 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>no</u>
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 2</u> , 19 <u>59</u> , to <u>Oct 6</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>at 6/59</u> , 19 <u>59</u> , and that death occurred at <u>11:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John O. Robben</u>		ADDRESS (Street, city or town, state) <u>7930 Beagria Ave Silver Spring Md</u>	
PHYSICIAN'S NAME (Type) <u>John O. Robben</u>		DATE SIGNED <u>Oct 7/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>10-7-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>Oct 8 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11402

OFFICE OF THE
SHERIFF OF DEATH

11550

1

Robert A. Thompson, Baltimore, Md.
1907-1908
John A. Thompson, Baltimore, Md.
1907-1908

CERTIFICATE OF DEATH

11496

Reg. Dist. No.

11551

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown	c. LENGTH OF STAY IN 1b years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD # 1, Box 54		d. STREET ADDRESS RFD #1, Box 54	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Celeste Middle Pearl Last Beall		4. DATE OF DEATH Month October Day 23 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 16, 1901
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Cedar Grove, Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles Lee Watkins	
14. MOTHER'S MAIDEN NAME Minnie A. King		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. ---		17. INFORMANT Wm. E. Beall, Box 54, Germantown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal obstruction 175.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) metastatic Carcinoma DUE TO (c) Carcinoma ovary			INTERVAL BETWEEN ONSET AND DEATH 1 hours 6 mo. 18 mo
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April , 1958, to Oct 23 , 1959, that I last saw the deceased alive on Oct 22 , 1959, and that death occurred at 12:05 P. from the causes and on the date stated above.			
ACTUAL SIGNATURE Vernon E. Martens		ADDRESS (Street, city or town, state) Germantown, Md. DATE SIGNED Oct 24, 59	
PHYSICIAN'S NAME (Type) Vernon E. Martens		Germantown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/26/59	22c. NAME OF CEMETERY OR CREMATORY Upper Seneca Baptist	22d. LOCATION (City, town, or county) (State) Cedar Grove, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Oliver L. Johnson		ADDRESS Damascus, Md.	
24a. REC'D BY REGISTRAR DATE OCT 28 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kiana	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

11503

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>1 mth</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eventide Nursing Home</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Spencerville R.R. Maryland</u>			
				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) <u>Rural</u> First <u>T</u> Middle <u>J</u> Last <u>Beardsley</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>23</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-May 26, 1884</u>	
				9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>AT Home</u>			
11. BIRTHPLACE (State or foreign country) <u>Iowa</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Samuel T. Jordan</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Prince</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Records</u>			
17. INFORMANT <u>Records</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Insufficiency</u> DUE TO <u>443X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac Enlargement</u> DUE TO <u>Hypertension</u> (c) <u>2 yrs.</u> 5 years. 24 years.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>10/23/1959</u> to <u>10/23/1959</u> , that I last saw the deceased alive on <u>10/23/1959</u> , and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert A. Hare</u>				ADDRESS (Street, city or town, state) <u>7600 Carroll Ave. Tak Park, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Robert A. Hare Md.</u>				DATE SIGNED <u>10/23/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 27, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lakewood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>HOLLY, MICHIGAN</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u>				ADDRESS <u>254 Carroll St. D.C.</u>		24a. REC'D BY REGISTRAR <u>DATE OCT 26 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur Walters</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1-1-03

NAME OF DECEASED _____		SEX _____		AGE _____	
PLACE OF BIRTH _____		DATE OF BIRTH _____		PLACE OF DEATH _____	
OCCUPATION _____		CAUSE OF DEATH _____		MANNER OF DEATH _____	
DATE OF DEATH _____		TIME OF DEATH _____		PLACE OF INTERMENT _____	
SIGNATURE OF DECEASED _____		SIGNATURE OF WITNESS _____		SIGNATURE OF PHYSICIAN _____	
SIGNATURE OF CLERK _____		SIGNATURE OF REGISTRAR _____		SIGNATURE OF JUDGE _____	

RECEIVED
 JAN 1 1903
 BALTIMORE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11498

Reg. Dist. No.

11552

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE D. C. b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Silver Theatre				d. STREET ADDRESS 312 Quackenbos St., N.W.			
3. NAME OF DECEASED (Type or print) First Aaron Middle Gilbert Last Berch				4. DATE OF DEATH Month 10 Day 28 Year 19 59			
5. SEX Male	6. COLOR OR RACE Col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 6, 1913		9. AGE (In years last birthday) 46 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waiter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Chicago, Ill.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Aaron Gilbert Berch				14. MOTHER'S MAIDEN NAME Ada Lucas			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 677/43 1/31/46		17. INFORMANT Olga Berch Woods, 1342 Randolph St., N. W.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral concussion 900.6 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture of skull DUE TO (c) Fall down stairs						INTERVAL BETWEEN ONSET AND DEATH few minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell down stairs at Silver Theatre					
20c. TIME OF INJURY Month, Day, Year 10-28-59 Hour 11 o. m. pm.		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Theatre		20f. (City or town) Silver Spring (County) Montg (State) MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschert M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) FRANK J. BROSCERT				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 10-28-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 3, 1959		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cem.		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE William H. Jones				24a. REC'D BY REGISTRAR NOV 2 '59		24b. REGISTRAR'S SIGNATURE William H. Jones	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

11553

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>DC</i> b. COUNTY <i>Washington</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Fairland</i>				c. LENGTH OF STAY IN 1b <i>47X-3</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Fairland Hospital</i>				d. STREET ADDRESS <i>1426 Sheridan St. NW</i>			
3. NAME OF DECEASED (Type or print) First <i>Sda</i> Middle <i>Berger</i> Last <i>Berger</i>				4. DATE OF DEATH Month <i>Oct</i> Day <i>16</i> Year <i>1959</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1872 June 16, 1874</i>	9. AGE (In years last birthday) <i>87</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House duties</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Austria</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Benjamin</i>				14. MOTHER'S MAIDEN NAME <i>Bertha</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>082-05-7356</i>		17. INFORMANT <i>Heber Friedlander</i> Address <i>1426 Sheridan St. NW</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>443X Congestive Heart Failure - Acute</i> DUE TO <i>1 day</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive + Arteriosclerotic Heart Disease</i> <i>many years?</i> DUE TO <i>Dissecting</i> (c) <i>Generalized Arteriosclerosis</i> <i>?</i>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>March</i> , 19 <i>54</i> , to <i>10/16</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>10/15</i> , 19 <i>59</i> , and that death occurred at <i>7:15 P.M.</i> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <i>Benjamin Isaacson</i> M.D. <i>2733 Alachua Ave. N.W.</i>				<i>Washington 12 - DC</i>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>10/18-1959</i>		<i>Mt. Lebanon</i>		<i>Kong Island Ky.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE	
<i>Goldberg Funeral Home Wash. D.C.</i>				<i>OCT 19 '59</i>		<i>William S. Evans</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the green papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11554

CERTIFICATE OF DEATH

11500

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Louisiana b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 13 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Dwanna Middle Ruth Last BERRY				4. DATE OF DEATH Month October Day 22 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-3-56	
9. AGE (In years lost birthday) yrs. 3		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11. BIRTHPLACE (State or foreign country) Louisiana		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Norwood Dale BERRY				14. MOTHER'S MAIDEN NAME Betty Holward			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		INFORMANT Address (Father) Norwood Berry Same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 754.5 DUE TO Congenital Heart Disease, (Atrial Septal Defect, anomalous pulmonary venous return) Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Post surgical correction status (c) Post surgical correction status							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9 October, 19 59 to 22 October, 19 59 that I last saw the deceased alive on 22 October, 19 59 , and that death occurred at 8:45 AM from the causes and on the date stated above.							
ACTUAL SIGNATURE J. E. McClenathan				ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda Md. 10-22-59			
PHYSICIAN'S NAME (Type) J. E. MC CLENATHAN CDR MC USN				U.S. Naval Hospital, Bethesda Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-27-59		22c. NAME OF CEMETERY OR CREMATORY Winnifield Cemetery		22d. LOCATION (City, town, or county) (State) Winnifield La.	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey				ADDRESS 557 Wisconsin Ave. Bethesda Md.		24a. REC'D BY REGISTRAR OCT 27 59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

11500

11550

Montgomery
 Bethesda (Md.) 13 days
 U.S. Naval Hospital, Bethesda Md. 10 East Coast Street

October 22
 10-22-50
 None
 None
 None

Harwood Eric
 (Tobey) Harwood Betty
 None

10-22-50
 10-22-50
 10-22-50

October 22
 10-22-50
 U.S. Naval Hospital, Bethesda Md.
 10-22-50

10-22-50
 10-22-50
 10-22-50

11555

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D.C. b. COUNTY Mont.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON, D.C.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington (15)		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Nathan Middle Block Last Block			4. DATE OF DEATH Month Oct. Day 18 Year 1959		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 16, 1904		9. AGE (In years last birthday) 65 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) D.C. Court - Bridge Inspector		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Missouri	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Paul Block		
14. MOTHER'S MAIDEN NAME Celia Miller			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. 486-16-6005			17. INFORMANT Marlyn J. Block Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO pulmonary edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) congestive heart failure DUE TO (c) myocardial infarctions, acute, old - 1 1/2 years					INTERVAL BETWEEN ONSET AND DEATH 2-3 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) diabetes mellitus					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from Dec 10, 1958 , to 10/18, 1959 , that I last saw the deceased alive on 10/18, 1959 , and that death occurred at 12:45 M, from the causes and on the date stated above.					
ACTUAL SIGNATURE Charles Savarese		ADDRESS (Street, city or town, state) 4890 Batry Lane, Beth. Md. 10/18/59			
PHYSICIAN'S NAME (Type) CHARLES J. SAVARESE, Jr. M.D.		DATE SIGNED 10/18/59			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
BURIAL	OCT. 20, 1959			ST. LOUIS MO.	
23. FUNERAL DIRECTOR'S SIGNATURE B. Langhansky & Sons Wash D.C.		ADDRESS 3501-14 St NW		24a. REC'D BY REGISTRAR DATE OCT 21 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TESTIFICATE OF DEATH

1855

[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page. The text appears to be a formal declaration or record.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11502

11556

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>1 wk.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brookeville</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Harvey</u> Middle <u>W.</u> Last <u>Boswell</u>				4. DATE OF DEATH Month <u>10</u> Day <u>6</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 6</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Postmaster</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Gaithersburg, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Rodney Boswell</u>				14. MOTHER'S MAIDEN NAME <u>Jenkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>+</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Hospital Records</u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>177X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Ventricular Fibrillation</u> (c) <u>Prostatic Co + Cachexia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs</u> <u>16 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>April</u> , 19 <u>53</u> , to <u>10-6-</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10-6-</u> , 19 <u>59</u> , and that death occurred at <u>3:30</u> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John Bosby Ziegler</u> M.D.				ADDRESS (Street, city or town, state) <u>Olney, Md.</u>		DATE SIGNED <u>6 Oct 59</u>	
PHYSICIAN'S NAME (Type) <u> </u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct. 9, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Salem Meth.</u>		22d. LOCATION (City, town, or county) (State) <u>Brookeville, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Roy W. Zauber</u> ADDRESS <u>Saylorsville Md.</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 9 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Carlton S. Kenna</u>		

11558

CERTIFICATE OF DEATH

1-1-1900

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		35		M		W		1928		MOBILE, ALABAMA		MOBILE		ALABAMA		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION	
APRIL 4, 1968		MEMPHIS, TENNESSEE		MEMPHIS		TENNESSEE		UNITED STATES		SHOOTING		SUICIDE		ATTORNEY		HIGH SCHOOL	
DATE OF REPORT		PLACE OF REPORT		CITY		STATE		COUNTRY		REPORTED BY		TITLE		INSTITUTION		ADDRESS	
APRIL 4, 1968		MEMPHIS, TENNESSEE		MEMPHIS		TENNESSEE		UNITED STATES		JAMES EARL RAY		ATTORNEY		MEMPHIS		MEMPHIS, TENNESSEE	
DATE OF EXAMINATION		PLACE OF EXAMINATION		CITY		STATE		COUNTRY		EXAMINED BY		TITLE		INSTITUTION		ADDRESS	
APRIL 4, 1968		MEMPHIS, TENNESSEE		MEMPHIS		TENNESSEE		UNITED STATES		JAMES EARL RAY		ATTORNEY		MEMPHIS		MEMPHIS, TENNESSEE	

11532

CERTIFICATE OF DEATH

11503

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE		c. LENGTH OF STAY IN 1b 2 MONTHS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION this is her daughter's residence.		d. STREET ADDRESS WASHINGTON 47 x-3	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ETHEL Middle B. Last BRODERICK		4. DATE OF DEATH Month 10 Day 8 Year 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT 9-7-93
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JEFFERSON BOWEN		14. MOTHER'S MAIDEN NAME BLANCHE PEED	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. INFORMANT Address WASH. D.C.	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Pancreas 157x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) no		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. no 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-1-1959 , to 10/8-1959 , that I last saw the deceased alive on 10/7-1959 , and that death occurred at 7:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 301 Constitution St. Wash. D.C. DATE SIGNED Wash. D.C.			
ACTUAL SIGNATURE A. Keene Bowie		SIGNATURE OF REGISTRAR Wash. D.C.	
PHYSICIAN'S NAME (Type) A. KEENE BOWIE			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-12-59	
22c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins ADDRESS WASH. D.C.		24a. REC'D BY REGISTRAR DATE OCT 19 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

4323 Howard

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11323

WASHINGTON

2 NOV 11

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11557 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 8, 11 Film 250 10-26-59 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>VIENNA</u> 83x-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>R.F.D. #1 Box 163</u>			
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>St. Clair</u> Middle <u>Brookes Jr.</u> Last				4. DATE OF DEATH Month <u>10</u> Day <u>13</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 18, 1888</u> 71 yrs.	
9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Law</u>		11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN ST. CLAIR BROOKES, SR.</u>				14. MOTHER'S MAIDEN NAME <u>LUCY NEWTON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT <u>Police record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Collapsed while playing golf at Burning Tree C.C.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHE</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>10-13-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/15/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>IVY HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ALEXANDRIA, VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Hawley & Sons, Inc.</u>				ADDRESS <u>1756 Pa. Ave., N.W.</u>		24a. REC'D BY REGISTRAR <u>DATE OCT 16 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kians</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 8 & 9, Film G-253 12/24/59.cac.
11558
CERTIFICATE OF DEATH

11565

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1108 Dryden St.		d. STREET ADDRESS 1108 Dryden St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Elizabeth M. Middle Browne Last		4. DATE OF DEATH Month October Day 13 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/21/77 1887
9. AGE (In years last birthday) 72 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wilson Miller		14. MOTHER'S MAIDEN NAME Mary Frances Darley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 483-20-0694	
17. INFORMANT Mary Gardner		2008 Osborn Dr. Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal bronchopneumonia 260 X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) Cardio vascular disease (c) Diabetes mellitis		INTERVAL BETWEEN ONSET AND DEATH 3 da 2 YRS 6 YRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Apr 4, 1934 to Oct 13, 1959 , that I last saw the deceased alive on Oct 12, 1959 , and that death occurred at 3:10 p. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE E. E. Quayle		ADDRESS (Street, city or town, state) 1822 Biltmore St NW Washington D.C.	
PHYSICIAN'S NAME (Type) E. E. Quayle		DATE SIGNED Oct 15 '59	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 10/15/59	
22c. NAME OF CEMETERY OR CREMATORY Congressional Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		24a. REC'D BY REGISTRAR 2901 14th St. N.W. Washington 9, D.C.	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines		DATE OCT 15 '59	

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11506

11559

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 17 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia		b. COUNTY 83x-3					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS 5403 Youngblood Street					
3. NAME OF DECEASED (Type or print) Virginia Bean BRYAN		First Virginia		Middle Bean		Last BRYAN		4. DATE OF DEATH Month October		Day 9		Year 19 59	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-4-07		9. AGE (In years lost birthday) 52 yrs.		IF UNDER 1 YEAR Months 52		IF UNDER 24 HRS. Days 52	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None				11. BIRTHPLACE (State or foreign country) Kentucky				12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Watts BEAN						14. MOTHER'S MAIDEN NAME Lu KIDWELL							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. (Husband) Louis A Bryan Same as #2				INFORMANT Same as #2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Pancreas 157x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) DUE TO										INTERVAL BETWEEN ONSET AND DEATH 1 yr			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 22 Sept. , 19 59 , to 9 October , 19 59 , that I last saw the deceased alive on 9 October , 19 59 , and that death occurred at 8:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda Md. 10-9-59													
ACTUAL SIGNATURE R. G. Muth				M.D. U.S. Naval Hospital, Bethesda Md.									
PHYSICIAN'S NAME (Type) R.G. MUTH LT MC USN				U.S. Naval Hospital, Bethesda Md.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-13-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National				22d. LOCATION (City, town, or county) Arlington Va.					
23. FUNERAL DIRECTOR'S SIGNATURE A. C. Pumphrey				ADDRESS 7557 Wisconsin Ave. Bethesda Md.				24a. REC'D BY REGISTRAR 13 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

11558

Virginia

Montgomery

McLean

IV days

Leatherda (Jural)

5-03 Youngblood Street

U.S. Naval Hospital, Bethesda, Md.

BRYAN

Beam

Virginia

October

White

9-1-07

None

Houswife

AN KIDNAP

NOV 2 1907

(Hospital) Louis A Bryan, Same as 2

No

R. P. [Signature]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11507

11560

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN lb 5 hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Nettie Middle Virginia Last Burdette				4. DATE OF DEATH Month October Day 5 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8.31.1881	
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months 78		11. IF UNDER 24 HRS. Days 78		12. IF UNDER 24 HRS. Hours 78 Min. 78	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Maryland			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME George Brown				14. MOTHER'S MAIDEN NAME Jennie Young			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --				16. SOCIAL SECURITY NO. --			
17. INFORMANT Hospital, Records				Address --			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Leukemia 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) Generalized Arteriosclerosis DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 2 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from January 19 41 to Oct. 5, 19 59 , that I lost saw the deceased alive on Oct. 4, 19 59 , and that death occurred on 1:08 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE M. M. Boyer M.D.				ADDRESS (Street, city or town, state) Druid Theatre Building,		DATE SIGNED 10/5/59	
PHYSICIAN'S NAME (Type) M. M. Boyer, M. D., Damascus, Md.				10.5.59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/7/59		22c. NAME OF CEMETERY OR CREMATORY Montgomery Meth.		22d. LOCATION (City, town, or county) (State) Clagetsville, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Olin L. Mohan				ADDRESS Damascus, Md.		24a. REC'D BY REGISTRAR DATE OCT 7 '59	
				24b. REGISTRAR'S SIGNATURE Arthur A. Hana			

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

500

Geoffrey Brown

• 1954 •

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11508

CERTIFICATE OF DEATH

Reg. Dist. No.

11561

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN lb 33 years		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4136 Leland St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) PEARL Mary BURDINE		4. DATE OF DEATH Oct. 10, 1959		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 23, 1875	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR 7 Months 17 Days 19 Hours 59 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk - Govt.		10b. KIND OF BUSINESS OR INDUSTRY Retired		
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William T. Burdine		14. MOTHER'S MAIDEN NAME Susan Wagner		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) - - - - -		16. SOCIAL SECURITY NO. None		
INFORMANT Adelia J. Downey - Sister - Item #2		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 331X DUE TO Cerebrovascular Accident Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Atherosclerosis DUE TO (c) Atherosclerosis				INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Sept 9, 1959 to Oct 10, 1959 , that I lost saw the deceased alive on Oct 9, 1959 , and that death occurred at 10 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8106 Maple Ridge Rd Bethesda, Md				
ACTUAL SIGNATURE W. T. Joyce		DATE SIGNED 10/10/59		
PHYSICIAN'S NAME (Type) William T. Joyce, M. D.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-13-59	22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey		24a. REC'D BY REGISTRAR DATE OCT 14 '59		
24b. REGISTRAR'S SIGNATURE Arthur S. Hume				

CERTIFICATE OF DEATH

11561

Montgomery

Gray Chase

33 years

Gray Chase

11561 Chase Street

11561 Chase Street

BURDINE

PEARL Mary

Oct 10

Feb 23, 1970

Female White

Black - 6'0"

Black - 6'0"

Washington, D. C.

Gray Chase

Gray Chase

Gray

Gray - 6'0"

Gray Chase
Gray Chase
Gray Chase

Oct 10

Oct 10

Gray Chase

Gray Chase

Gray Chase

Gray Chase

Gray Chase

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11504
CERTIFICATE OF DEATH

11509

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Hontgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>D.C.</i> b. COUNTY <i>✓</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i> 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington San + Hospital</i>		d. STREET ADDRESS <i>Apt 204, 4912 New Hampshire Ave NW</i>	
3. NAME OF DECEASED (Type or print) <i>Edna (NAN) Bursack</i>		4. DATE OF DEATH <i>10-27</i> 19 <i>59</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-26-81</i>
9. AGE (In years last birthday) <i>78</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>High School teacher</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Miss.</i>		12. CITIZEN OF WHAT COUNTRY? <i>American</i>	
13. FATHER'S NAME <i>Unknown to pt (Bursack)</i>		14. MOTHER'S MAIDEN NAME <i>Anna (unknown)</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1 Coronary Occlusion</i> DUE TO (b) <i>C.V. Accident</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <i>Arteriosclerosis</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>18 hours</i> <i>18 hours</i> <i>years</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Oct 25, 1959</i> to <i>Oct 27, 1959</i> , that I last saw the deceased alive on <i>Oct 27, 1959</i> , and that death occurred at <i>7:27 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Robert A. Hare</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>7600 Carroll Ave, Takoma Park, Md. 10/27</i>	
PHYSICIAN'S NAME (Type) <i>Robert A. Hare</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<i>BURIAL</i>	<i>11-2-59</i>	<i>Greenwood</i>	<i>Jackson Miss</i>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>DEAL FUNERAL HOME 4812 Ga Ave D.C.</i>		24a. REC'D BY REGISTRAR DATE <i>NOV 2 '59</i> 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kneass</i>	

11504

CERTIFICATE OF DEATH

11504

[Faint, illegible text and markings on a death certificate form, including fields for name, date, and cause of death.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11562 **CERTIFICATE OF DEATH**

11510

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>10 da</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Edna</u> Middle <u>Pearl</u> Last <u>Bushong</u>				4. DATE OF DEATH Month <u>10</u> Day <u>23</u> Year <u>1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/17/93</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>6</u>		IF UNDER 24 HRS. Hours <u>6</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gov't. Employee</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Samuel DW Everett</u>				14. MOTHER'S MAIDEN NAME <u>Mary Jane Persing</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Silver Sp. Md.</u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>465X Pulmonary embolism</u> DUE TO (b) <u>One year +</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>One year +</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Status Postoperative - Resection Transverse Colon</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>9 Oct</u> , 19 <u>59</u> , to <u>23 Oct</u> , 19 <u>59</u> that I last saw the deceased alive on <u>22 Oct</u> , 19 <u>59</u> , and that death occurred at <u>7:45</u> A.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Edward C. Wilson Jr.</u>				M.D. <u>1801 Eye St. N.W. Wash. DC</u> <u>23 Oct 59</u>			
PHYSICIAN'S NAME (Type) <u>Edward C. Wilson, Jr.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/26/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>S. H. Humes Co</u>				ADDRESS <u>2901-14 St. N.W.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 26 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11562

CERTIFICATE OF DEATH

11562

1

County of ... State of ...

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 1d, 7 & 22 a & b, Film G250 10/23/59 lwk
11563
CERTIFICATE OF DEATH

11511

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON		c. LENGTH OF STAY IN 1b 12 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Died at home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELSPET Middle GAREN Last BUTLER		4. DATE OF DEATH Month OCT Day 19 Year 1959	
5. SEX FEMALE	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-5-1914
9. AGE (In years last birthday) 45 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECRETARY		10b. KIND OF BUSINESS OR INDUSTRY Woodard Appt	
11. BIRTHPLACE (State or foreign country) COLONGE, GERMANY		12. CITIZEN OF WHAT COUNTRY? British	
13. FATHER'S NAME William JACKSON		14. MOTHER'S MAIDEN NAME ELSPET GAREN PIRIE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 577-01-6290	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of colon with metastases 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 15 , 19 59 , to Oct 14 , 19 59 , that I last saw the deceased alive on Oct 14 , 19 59 , and that death occurred at 7 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE H. B. ORLEANS		DATE SIGNED 9500 Coleville Rd Silver Spring, Md	
PHYSICIAN'S NAME (Type) H. B. ORLEANS			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 17, 1959	22c. NAME OF CEMETERY OR CREMATORY MONTGOMERY	22d. LOCATION (City, town, or county) (State) BEALLSVILLE, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Constance C. Hilton		24a. REC'D BY REGISTRAR OCT 20 '59	
ADDRESS Barnesville, Md		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CHARLES M. BOSTER -

Alcohol T. Bottle 1000

1

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11564 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11512

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Woodmoor Bowling Alley		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George H First Middle Last		4. DATE OF DEATH Oct. 14, 1959 Month Day Year	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 19, 1899
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Gov. Retired		10b. KIND OF BUSINESS OR INDUSTRY Information Receptionist	
11. BIRTHPLACE (State or foreign country) New Hampshire		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jairus James Came		14. MOTHER'S MAIDEN NAME Etta Hobbs	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Frieda M. Came (wife) Address Item 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED Oct. 14, 1959	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL		22b. DATE THEREOF 10/16/59	
22c. NAME OF CEMETERY OR CREMATORY Forest Glade Cemetery		22d. LOCATION (City, town, or county) (State) Somersworth, New Hampshire	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Ziska		24a. REC'D BY REGISTRAR OCT 16 '59	
ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE Arthur S. Knecht	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

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11565

CERTIFICATE OF DEATH

11513

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 87 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 2206 Flagler Place, N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Patricia Sharon Carmichael		4. DATE OF DEATH Month Day Year October 8, 1959	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 31, 1959
9. AGE (In years last birthday) 6 yrs.		10. IF UNDER 1 YEAR Months 6 Days 8 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Roland S. Carmichael		14. MOTHER'S MAIDEN NAME Isabelle Payne	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
INFORMANT The Medical Record, Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, Right upper Lobe DUE TO 493X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Epidural Hematoma, Right Parietal			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 13, 1959 , to October 8, 1959 , that I last saw the deceased alive on October 8, 1959 , and that death occurred at 1:20 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center, Bethesda 14, Maryland DATE SIGNED 10-8-59			
ACTUAL SIGNATURE William S. Sly, M.D.		M.D. The Clinical Center	
PHYSICIAN'S NAME (Type) WILLIAM S. SLY, M.D.		National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10.13.59	22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cem.	22d. LOCATION (City, town, or county) (State) Arlington, Va.
23. FUNERAL DIRECTOR'S SIGNATURE Robert S. M. Guire		24a. REC'D BY REGISTRAR DATE OCT 13 '59	
ADDRESS 1820 9th St., N.W. Washington, D.C.		24b. REGISTRAR'S SIGNATURE Arthur S. Kneiss	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

2144 J. Neurosci., July 26, 2006 • 26(30):2140–2145

2505 10

Abstract

W. H. Jones, Jr.

The Classical Center, Bethesda, Md.

Leadership

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Director of Colonial Affairs

Search

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1990-1991

The Medical Record.

9.15

The Clinical Center, Bethesda, Md.

Incision, Right upper lobe

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Department of Health, Education and Welfare

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62-0000000-0000000

The National Institute of Health
Bethesda, Maryland

WILLIAM S. BIRN

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
Reg. Dist. No. 11514										
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 140 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Mississippi b. COUNTY ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Meridian d. STREET ADDRESS Route # 6, Box 33 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Raymond (None) Chappell					4. DATE OF DEATH Month Day Year October 29 1959					
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 9, 1940		9. AGE (In years last birthday) yrs. 19		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student			10b. KIND OF BUSINESS OR INDUSTRY None			11. BIRTHPLACE (State or foreign country) Mississippi			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Willie Chappell					14. MOTHER'S MAIDEN NAME Mattie L. Young					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 425-72-1213		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Respiratory failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 955 x (b) Some mechanical failure of Respirator DUE TO (c) Polyneuropathy Sudden Months PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute broncho-pneumonia INTERVAL BETWEEN ONSET AND DEATH Sudden Months										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Mechanical failure of Respirator							
20c. TIME OF INJURY Month, Day, Year 3:15 p. m. 10-29-59			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N.I.H. Hosp		20f. (City or town) (County) (State) Bethesda Montg. Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE Frank S. Broschart EXAMINER'S NAME (Type) FRANK S. BROSCART, M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) 10-31-59		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City, town, or county) (State) Meridian Miss			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Fraxers Funeral Home					24a. REC'D BY REGISTRAR DATE NOV 2 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11567

CERTIFICATE OF DEATH

Reg. Dist. No.

11515

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 35 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1907 GRACE CHURCH ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LESLIE Middle MERLE Last CHRISTIE		4. DATE OF DEATH Month OCT. Day 26 Year 19 59	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/25/81
9. AGE (In years lost birthday) yrs. 78		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Orthodontist (retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MILTON H. CHRISTIE		14. MOTHER'S MAIDEN NAME JOSEPHINE H. RHODES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. INFORMANT Address Mrs. Elvene C. Christie, 1907 Grace Church Rd.	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial Degeneration DUE TO (c) Myocardial infarction		18. INTERVAL BETWEEN ONSET AND DEATH 6 days 2 yrs 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February , 19 54 , to 10/26 , 19 59 , that I last saw the deceased alive on 10/25 , 19 59 , and that death occurred at 7:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Merrill M. Cross M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 8248 Germantown 10/26/59	
PHYSICIAN'S NAME (Type) MERRILL M. CROSS M.D. Silver Spring, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 10/29/59	
22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CREMATORY		22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Ziska		24a. REC'D BY REGISTRAR DATE OCT 28 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

CERTIFICATE OF DEATH

1955



NAME

DATE

STATE

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

RELIGION

OCCUPATION

1

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

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DATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 11568
 CERTIFICATE OF DEATH

Reg. Dist. No. 11516

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HOWARD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. LENGTH OF STAY IN 1b 3 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HIGHLAND			
				d. STREET ADDRESS 13X-2			
3. NAME OF DECEASED (Type or print) First Middle Last CHRISTOPHER CLAUDE CISSEL				4. DATE OF DEATH Month Day Year OCTOBER 20 19 59			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/23/80	
9. AGE (In years lost birthday) yrs. 79		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME PHILLIP CISSEL				14. MOTHER'S MAIDEN NAME ELLEN MARTHA ZEIGLER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 218-36-1088			
				17. INFORMANT HOSPITAL RECORDS Address OLNEY, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism DUE TO (b) Phlebotrombosis (saphenous) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Pulmonary infarction PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of prostate INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July , 19 46 , to Oct 20 , 19 57 , that I last saw the deceased alive on Oct 20 , 19 57 , and that death occurred at 4:05 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Charles S. Whitaker M.D.							
PHYSICIAN'S NAME (Type) C. S. WHITAKER, M. D.				CLARKSVILLE, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-23-59		22c. NAME OF CEMETERY OR CREMATORY Mt. Zion		22d. LOCATION (City, town, or county) (State) Highland Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higginbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR OCT 26 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thoma	

ADULT INDEX

21568

CERTIFICATE OF DEATH

11516

WESTCHESTER COUNTY GENERAL HOSPITAL
LINCOLN 2 DAYS
HAYLAND
HOWARD
NAME CHRISTOPHER ALANOR
SEX MALE
RACE WHITE
FATHER
MOTHER
DATE OF BIRTH
PLACE OF BIRTH
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH

Handwritten notes:
1. ...
2. ...
3. ...
4. ...
5. ...
6. ...
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9. ...
10. ...

DATE OF BIRTH 10-23-22
PLACE OF BIRTH
DATE OF DEATH 11-10-22
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH
SIGNATURE
DATE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11569

11517

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 8 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edith Middle Last Clarke		4. DATE OF DEATH Month October Day 29 Year 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2.10.1883
9. AGE (In years lost birthday) 76 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Electrical Engr. Professor	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Ridgley Clarke		14. MOTHER'S MAIDEN NAME Susan Dorsey OWENS Owings	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. ?	
INFORMANT Hospital Records		Address Olney, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute myocardial infarction DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 Uremia due to nephrosclerosis 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 19 57 , to Oct 29 , 19 59 , that I last saw the deceased alive on Oct 28 , 19 59 , and that death occurred at 8:10 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
ACTUAL SIGNATURE Charles S. Whitaker, M.D.			
PHYSICIAN'S NAME (Type) C. S. Whitaker, M.D. Clarksville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-31-59	22c. NAME OF CEMETERY OR CREMATORY St. Johns	22d. LOCATION (City, town, or county) (State) Ellicott City, Md
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md		24a. REC'D BY REGISTRAR NOV 2 '59	
ADDRESS _____		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11570

CERTIFICATE OF DEATH

Reg. Dist. No.

11518

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 1 day d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital, Bethesda, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY 83X-3 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington d. STREET ADDRESS 2204 S. Knoll Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Grace Middle Emmons Last CLIFFORD		4. DATE OF DEATH Month October Day 21 Year 1959	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-15-82
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months 77 Days 77 Hours 77 Min. 77	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Michigan	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Melrey Emmons		14. MOTHER'S MAIDEN NAME Augusta Dimler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None INFORMANT Hospital Records Address	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 24 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 20 October, 1959 to 21 October, 1959 , that I last saw the deceased alive on 21 October, 1959 , and that death occurred at 6:45A M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) U. S. Naval Hospital, NMMC, Bethesda, Md. DATE SIGNED 10-21-59	
ACTUAL SIGNATURE P. S. Muth		M.D. U. S. Naval Hospital, NMMC, Bethesda, Md.	
PHYSICIAN'S NAME (Type) R. G. MUTH LT MC USN		U. S. Naval Hospital, NMMC, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Cremation 10/22/59		22b. DATE THEREOF 10/22/59	
22c. NAME OF CEMETERY OR CREMATORY Green Cemetery		22d. LOCATION (City, town, or county) (State) Detroit Michigan	
23. FUNERAL DIRECTOR'S SIGNATURE Demaine Funeral Home		ADDRESS S. Washington St., Alexandria, Va.	
24a. REC'D BY REGISTRAR OCT 23 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kinn	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11519

Reg. Dist. No.

11505

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> c. LENGTH OF STAY IN TB <u>25 min</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON SANITARIUM + Hosp</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENNESINGTON</u> d. STREET ADDRESS <u>3509 PERRY AVE.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>ISABELL</u> Last <u>COTTRELL</u>				4. DATE OF DEATH Month <u>10</u> Day <u>18</u> Year <u>1959</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>Wh</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-29-06</u>		9. AGE (In years last birthday) <u>53</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Belfast - Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Caldwell</u>				14. MOTHER'S MAIDEN NAME <u>Jane Mary Smith</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u> </u>				17. INFORMANT <u>Charles Cottrell</u>				Address <u>201 New Hamp. Hgts. Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u> </u> DUE TO (c) <u> </u>								INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				<u>10-18-59</u>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					
22b. DATE THEREOF <u>Oct. 21, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Prince Georges County Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u>						ADDRESS <u>254 Carroll Ave. NW DC</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Kneel</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneel</u>						DATE <u>OCT 21 '59</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

15210

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE	
5. PLACE OF BIRTH		6. DATE OF BIRTH		7. DATE OF DEATH		8. TIME OF DEATH	
9. PLACE OF DEATH		10. OCCUPATION		11. CAUSE OF DEATH		12. MANNER OF DEATH	
13. PREVIOUS ILLNESS		14. PREVIOUS SURGERY		15. PREVIOUS TRAUMA		16. PREVIOUS DRUGS	
17. PREVIOUS ALCOHOL		18. PREVIOUS TOBACCO		19. PREVIOUS OTHER		20. PREVIOUS OTHER	
21. PREVIOUS OTHER		22. PREVIOUS OTHER		23. PREVIOUS OTHER		24. PREVIOUS OTHER	
25. PREVIOUS OTHER		26. PREVIOUS OTHER		27. PREVIOUS OTHER		28. PREVIOUS OTHER	
29. PREVIOUS OTHER		30. PREVIOUS OTHER		31. PREVIOUS OTHER		32. PREVIOUS OTHER	
33. PREVIOUS OTHER		34. PREVIOUS OTHER		35. PREVIOUS OTHER		36. PREVIOUS OTHER	
37. PREVIOUS OTHER		38. PREVIOUS OTHER		39. PREVIOUS OTHER		40. PREVIOUS OTHER	
41. PREVIOUS OTHER		42. PREVIOUS OTHER		43. PREVIOUS OTHER		44. PREVIOUS OTHER	
45. PREVIOUS OTHER		46. PREVIOUS OTHER		47. PREVIOUS OTHER		48. PREVIOUS OTHER	
49. PREVIOUS OTHER		50. PREVIOUS OTHER		51. PREVIOUS OTHER		52. PREVIOUS OTHER	
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1. NAME OF DECEASED
2. SEX
3. AGE
4. RACE
5. PLACE OF BIRTH
6. DATE OF BIRTH
7. DATE OF DEATH
8. TIME OF DEATH
9. PLACE OF DEATH
10. OCCUPATION
11. CAUSE OF DEATH
12. MANNER OF DEATH
13. PREVIOUS ILLNESS
14. PREVIOUS SURGERY
15. PREVIOUS TRAUMA
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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11520

11571

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WOOD ACRES, MARYLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WOOD ACRES, MARYLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6007- MASSACHUSETTS AVENUE, N.W.				d. STREET ADDRESS 6007- MASSACHUSETTS AVENUE, N.W.			
3. NAME OF DECEASED (Type or print) First LELLIAN Middle N. Last DALY				4. DATE OF DEATH Month OCTOBER Day 31 Year 1959			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/27/1881		9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months 8 Days 4 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE - AT HOME				10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE - AT HOME		11. BIRTHPLACE (State or foreign country) NOKEVILLE, VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME SPOTWOOD SPINDLE			
14. MOTHER'S MAIDEN NAME MARY				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT EDWARD A. DALY (SON) Address 6007 MASS. AVE, WOOD ACRES			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) uremia 443x DUE TO congestive heart failure Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (c) hypertensive heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) diabetes mellitus							
INTERVAL BETWEEN ONSET AND DEATH 2 wk 4 mo. 10 yrs							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 9:50 p. m. Month, Day, Year 10 31 1959				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from April , 19 59 , to Oct. 31 , 19 59 , that I last saw the deceased alive on October 30 , 19 59 , and that death occurred at 9:50 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Flaine W. Murphy				ADDRESS (Street, city or town, state) DATE SIGNED 4812 Eliott St NW Washington 16 D.C.			
PHYSICIAN'S NAME (Type) FLAINE W. MURPHY, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/4/59		22c. NAME OF CEMETERY OR CREMATORY WASHINGTON NATIONAL CEMETERY		22d. LOCATION (City, town, or county) (State) SUTLAND, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE MARTIN W. HYSONG COMPANY				24a. REC'D BY REGISTRAR DATE D. NOV 3 '59			
24b. REGISTRAR'S SIGNATURE Arthur S. Frank							

11580

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

CERTIFICATE OF DEATH

Page One of Two

NAME OF DECEASED WILLIAM A. GALE		DATE OF DEATH 1945	
AGE 60		SEX MALE	
RACE WHITE		RELIGION METHODIST	
MARRIAGE WEDDED		EDUCATION HIGH SCHOOL	
OCCUPATION CLERK		RESIDENCE 1007 - MARSHBURNER AVENUE N.E.	
DATE OF BIRTH 1915		PLACE OF BIRTH WILMINGTON, DELAWARE	
DATE OF DEATH 1945		PLACE OF DEATH HOME	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
SIGNATURE OF DECEASED WILLIAM A. GALE		SIGNATURE OF WITNESS WILLIAM A. GALE	
DATE OF SIGNATURE 1945		DATE OF SIGNATURE 1945	
ADDRESS OF DECEASED 1007 - MARSHBURNER AVENUE N.E.		ADDRESS OF WITNESS 1007 - MARSHBURNER AVENUE N.E.	
CITY OF DECEASED WASHINGTON, D.C.		CITY OF WITNESS WASHINGTON, D.C.	
STATE OF DECEASED D.C.		STATE OF WITNESS D.C.	
COUNTY OF DECEASED D.C.		COUNTY OF WITNESS D.C.	
ZIP CODE OF DECEASED 20001		ZIP CODE OF WITNESS 20001	
FEDERAL IDENTIFICATION NUMBER 100-100000		FEDERAL IDENTIFICATION NUMBER 100-100000	
MAYOR'S OFFICE 1007 - MARSHBURNER AVENUE N.E.		MAYOR'S OFFICE 1007 - MARSHBURNER AVENUE N.E.	
CITY CLERK 1007 - MARSHBURNER AVENUE N.E.		CITY CLERK 1007 - MARSHBURNER AVENUE N.E.	
COUNTY CLERK 1007 - MARSHBURNER AVENUE N.E.		COUNTY CLERK 1007 - MARSHBURNER AVENUE N.E.	
STATE CLERK 1007 - MARSHBURNER AVENUE N.E.		STATE CLERK 1007 - MARSHBURNER AVENUE N.E.	
FEDERAL CLERK 1007 - MARSHBURNER AVENUE N.E.		FEDERAL CLERK 1007 - MARSHBURNER AVENUE N.E.	
MAYOR'S OFFICE 1007 - MARSHBURNER AVENUE N.E.		MAYOR'S OFFICE 1007 - MARSHBURNER AVENUE N.E.	
CITY CLERK 1007 - MARSHBURNER AVENUE N.E.		CITY CLERK 1007 - MARSHBURNER AVENUE N.E.	
COUNTY CLERK 1007 - MARSHBURNER AVENUE N.E.		COUNTY CLERK 1007 - MARSHBURNER AVENUE N.E.	
STATE CLERK 1007 - MARSHBURNER AVENUE N.E.		STATE CLERK 1007 - MARSHBURNER AVENUE N.E.	
FEDERAL CLERK 1007 - MARSHBURNER AVENUE N.E.		FEDERAL CLERK 1007 - MARSHBURNER AVENUE N.E.	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11572 Item 22 Film G251 10-30-59 et
CERTIFICATE OF DEATH

11521

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 1 day d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Mont. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chevy Chase d. STREET ADDRESS 4911 Essex Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Freeland Allyn DAUBIN		4. DATE OF DEATH Month Day Year October 24 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-8-86
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Crittenden C. DAUBIN		14. MOTHER'S MAIDEN NAME Ella BOWEN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW I & II		16. SOCIAL SECURITY NO. 547 46 6391	
17. INFORMANT (Daughter) Mrs. Elizabeth Hartman		Address Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Congestive Heart Failure DUE TO (b) Arteriosclerosis generalized and (c) Hemorrhage, secondary to gastric ulcer Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 24 hours 10 years 4 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 23 October 1959 to 24 October 1959 that I last saw the deceased alive on 24 October 1959 , and that death occurred at 5:45 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE James M. Young		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md.	
PHYSICIAN'S NAME (Type) J.M. YOUNG LT MC USN		DATE SIGNED 10-24-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-25-59	
22c. NAME OF CEMETERY OR CREMATORY Fort Rosecrans		22d. LOCATION (City, town, or county) (State) San Diego, Calif.	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Humphrey		24a. REC'D BY REGISTRAR OCT 27 '59	
ADDRESS 7557 Wisconsin Ave. Bethesda Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

11521

CENT. CASE OF DEATH

11521

Montgomery

Montgomery

Chase

1 day

Bedford (Hills)

U.S. Naval Hospital, Bethesda Md. 4411 Essex Ave.

24

October

DAVID

ALAN

WYOMING

2-8-86

White

U.S.

U.S. Government Hospital

U.S. Navy

MISS HORN

Colonel G. DAVID

Yes WW I & II PAT # 930 (Daughter) Mrs. Elizabeth Hartman Stone

[Faint, mostly illegible text block]

24 October 24 October 24 October

U.S. Naval Hospital, Bethesda Md. U.S. Naval Hospital, Bethesda Md.

San Diego, Calif.

San Diego, Calif.

San Diego, Calif.

CERTIFICATE OF DEATH

Reg. Dist. No.

11573

11522

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garrett Park		c. LENGTH OF STAY IN lb 2 Months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10930 Clermont Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DALE Middle G. Last DAVIDSON		4. DATE OF DEATH Month Oct. Day 24, Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 6, 1894
9. AGE (In years last birthday) yrs. 64		10. IF UNDER 1 YEAR Months 10 Days 18 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance agent		10b. KIND OF BUSINESS OR INDUSTRY Insurance	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William C. Davidson		14. MOTHER'S MAIDEN NAME Mary P. Nath	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 275-03-7506	
INFORMANT Wife Address Grace S. Davidson		Same as Item#2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion - 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Cardio Vascular Disease Hypertension DUE TO (c) 10 yr.			INTERVAL BETWEEN ONSET AND DEATH 24 Hr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 24 Oct , 19 59 , to 24 Oct , 19 59 , that I last saw the deceased alive on 24 Oct , 19 59 , and that death occurred at 5:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7936 Old Georgetown Rd., 10-25-59 DATE SIGNED			
ACTUAL SIGNATURE John G. Ball		M.D. 7936 Old Georgetown Rd., 10-25-59	
PHYSICIAN'S NAME (Type) JOHN G. BALL		Bethesda, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/28/59	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR DATE OCT 30 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK

1152

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12697

Reg. Dist. No.

11574

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>235 Oakdale Place</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Andrew Davis</u>				4. DATE OF DEATH Month Day Year <u>October 1 19 59</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>9/9/21</u>		9. AGE (In years last birthday) <u>38</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>			
13. FATHER'S NAME <u>Mose Davis</u>				14. MOTHER'S MAIDEN NAME <u>Sutton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> W.W.II		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT Address <u>Hospital records-Suburban Hospital</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary Thrombosis</u> (a), stating the underlying cause last. DUE TO (c) _____ Sudden </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED			
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		<u>Oct. 2, 1959</u>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>Oct. 5, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Shipped to: Levi Hamilton, Fun. Dir., Goldsboro, North Carolina</u>			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>W. Ernest Jarvis, Washington, D. C.</u>				24a. REC'D BY REGISTRAR <u>NOV 27 '59</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

REPLACEMENT CERTIFICATE*ORIGINAL CERTIFICATE
APPARENTLY SENT WITH THE BODY 11/29/59-mnb

MEDICAL CERTIFICATION

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 19

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11523

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE D.C. b. COUNTY <input checked="" type="checkbox"/>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 10001 Georgia Ave.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3			
f. STREET ADDRESS 600 Emerson St., N.W.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ghunward Middle Patterson Last Davis				4. DATE OF DEATH Month Oct. Day 20 Year 1959			
5. SEX male		6. COLOR OR RACE col.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 31, 1886	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer				10b. KIND OF BUSINESS OR INDUSTRY Grocery		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Benjamin Davis				14. MOTHER'S MAIDEN NAME Sallie Terrell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT Gwendolyn Bishop	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) 420.1 DUE TO (a) 420.1 (b) 420.1 (c) 420.1				INTERVAL BETWEEN ONSET AND DEATH sudden			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		10/24/59		Ash Memorial		Sandy Spring, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden				ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR DATE OCT 27 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

CERTIFICATE OF DEATH

Reg. Dist. No.

11576

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Georgia b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 11 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Keith Middle Howard Last Davis				4. DATE OF DEATH Month October Day 8 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 3, 1958		9. AGE (In years last birthday) 1 yrs.	10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None (Child)		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Howard E. Davis				14. MOTHER'S MAIDEN NAME Betty Cobble			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. None		INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure - post-operative 754.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congenital heart disease DUE TO (c) Life							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from September 27 1959 , to October 8, 1959 , that I last saw the deceased alive on October 8, 1959 , and that death occurred at 9:35 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center Bethesda 14, Maryland DATE SIGNED 10/9/59							
ACTUAL SIGNATURE Roland Folsie				M.D. The Clinical Center			
PHYSICIAN'S NAME (Type) Roland Folsie, M.D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur. Trans.		22b. DATE THEREOF 10-10-59		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Memorial		22d. LOCATION (City, town, or county) (State) Decatur, Georgia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE OCT 14 '59		24b. REGISTRAR'S SIGNATURE Arthur L. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Door is

Atlanta, Ga.

2999 Memorial Drive, SE

October

July 3, 1958

Georgia

U. S. A.

Betty Goble

The Medical Record

The Clinical Center, Bethesda, Md., Maryland

Cardiac failure - post-operative

Genital heart disease

Life

September 27, 59 October 6, 59

9:55p

October 6, 59

The Clinical Center
National Institute of Health
Bethesda, Md., Maryland

Robert A. Johnson, M.D.

10-10-59 Post Heart Memorial

Robert A. Johnson, Bethesda, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11525

CERTIFICATE OF DEATH

Reg. Dist. No.

11577

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10305 Montrose Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ETHEL N DEMAREST		4. DATE OF DEATH Month 10 Day 21 Year 1959	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/6/1874
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months 0 Days 15	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Hamilton Smith Neale		14. MOTHER'S MAIDEN NAME Elizabeth Bowden	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
INFORMANT Catherine Demarest-daughter-same 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inanition 450.0 DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) Generalized arteriosclerosis DUE TO (c) Generalized arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 3 months years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Recent fracture, right femur			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 19 59 , to 10-21 , 19 59 , that I last saw the deceased alive on 10-21 , 19 59 , and that death occurred at 5:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE JASON GEIGER		DATE SIGNED 10-21-59	
PHYSICIAN'S NAME (Type) JASON GEIGER, M.D.		M.D. 931 Pershing Drive, Silver Spring, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/24/59	
22c. NAME OF CEMETERY OR CREMATORY Christ Epis. Ch. Cem.		22d. LOCATION (City, town, or county) (State) Eastville, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR OCT 26 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Knaus	

1

11578

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 7 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ohio b. COUNTY Chesapeake c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 72X-3 d. STREET ADDRESS (no street address) e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Jaye Middle Riley Last Diamond		4. DATE OF DEATH Month October Day 14, Year 19 59					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 21, 1923	9. AGE (In years last birthday) 36 yrs.	10. IF UNDER 1 YEAR Months 6-8 Days hours		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) VA Registrar		10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) Ohio			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Terry Diamond		14. MOTHER'S MAIDEN NAME Mildred Riley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WW II		17. UNAVAILABLE The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest-Hypotension DUE TO 204.3 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Leukemia DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 8 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from October 7, 19 59 to October 14, 19 59 that I last saw the deceased alive on October 14, 19 59 , and that death occurred at 2:50 AM , from the causes and on the date stated above. 3:50 a.m. ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland							
ACTUAL SIGNATURE Charles E. Mengel, M.D.		DATE SIGNED 10/14/59					
PHYSICIAN'S NAME (Type) Charles E. Mengel, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Trans.		22b. DATE THEREOF 10-14-59		22c. NAME OF CEMETERY OR CREMATORY Rome Cemetery			
22d. LOCATION (City, town, or county) (State) Lawrence Co., Ohio							
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		ADDRESS Robert A. Pumphrey, Bethesda, Maryland		24a. REC'D BY REGISTRAR OCT 16 '59			
24b. REGISTRAR'S SIGNATURE Charles E. Mengel							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF OHIO

1917

Chas. F. Kugel, M.D.

1917

THE STATE OF OHIO, COUNTY OF CUYAHOGA, ss.

Chas. F. Kugel, M.D.

1917

July 21, 1917

Ohio

Government

Chas. F. Kugel, M.D.

Chas. F. Kugel, M.D.

The Medical Board of the State of Ohio, created by Chapter 107 of the General Code, Ohio, is hereby notified that the following named person has been appointed to the position of

Chas. F. Kugel, M.D.

Respiratory Arrest-Protection

6-8 hours

Acute Laryngitis

8 months

THE CLINICAL CENTER
HALL NO. 1, LANSING ST. N.W.
WASHINGTON, D.C.

Charles F. Kugel, M.D.

one certificate

10-1-17

Robert A. Thompson, Secretary, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11527

11533

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Washington D. C. b. COUNTY ✓				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville			c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Manor Country Club				d. STREET ADDRESS 6358-31st Street, N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First John Middle E Last Doane				4. DATE OF DEATH Month Oct. Day 5 Year 19 59				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 8, 1912		
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Oklahoma		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME John Wm. Doane				14. MOTHER'S MAIDEN NAME Dora Harden				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Vernon H Doane-brother-3802		Address N.W. Wash. DC Gramarcy St.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>Frank J. Broschart</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED		
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		10/6/59		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-8-59		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cem.		22d. LOCATION (City, town, or county) (State) Arlington, Virginia		
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland				ADDRESS		24a. REC'D BY REGISTRAR ACT 8 '59		
				24b. REGISTRAR'S SIGNATURE <i>Arthur P. Thomas</i>				

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11528

11579

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Howard</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gastbury R-2</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pleasant View Nursing Home</u>		d. STREET ADDRESS <u>Daisy</u> <u>13X-2</u>	
3. NAME OF DECEASED (Type or print) First <u>Channing</u> Middle <u>Dorsey</u> Last <u>Dorsey</u>		4. DATE OF DEATH <u>10-22-</u> <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-20-1874</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Hanson Dorsey</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mary Brown (daughter)</u>		Address <u>Chesapeake N.J.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO <u>2 yr</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERNAL BETWEEN ONSET AND DEATH <u>2 yr</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10-22-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/25/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Daisy</u>		22d. LOCATION (City, town, or county) (State) <u>Daisy, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>		ADDRESS <u>Rockville, Md.</u>	
24a. REC'D BY REGISTRAR <u>OCT 27 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Robert L. Snowden</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>10/15/1918</i>		5. TIME OF DEATH <i>10:00 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. OCCUPATION <i>Teacher</i>		8. CAUSE OF DEATH <i>Heart Disease</i>		9. MANNER OF DEATH <i>Natural</i>	
10. SIGNATURE OF EXAMINER <i>Dr. J. H. Smith</i>		11. SIGNATURE OF ATTENDING PHYSICIAN <i>Dr. J. H. Smith</i>		12. SIGNATURE OF WITNESSES <i>John Doe, Mary Doe</i>	
13. SIGNATURE OF CORONER <i>John Doe</i>		14. SIGNATURE OF JURY <i>John Doe, Mary Doe</i>		15. SIGNATURE OF JUDGE <i>John Doe</i>	
16. SIGNATURE OF CLERK <i>John Doe</i>		17. SIGNATURE OF SHERIFF <i>John Doe</i>		18. SIGNATURE OF DEPUTY SHERIFF <i>John Doe</i>	
19. SIGNATURE OF JAILER <i>John Doe</i>		20. SIGNATURE OF JAILER'S CLERK <i>John Doe</i>		21. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>	
22. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>		23. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>		24. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>	
25. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>		26. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>		27. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>	
28. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>		29. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>		30. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>	
31. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>		32. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>		33. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>	
34. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>		35. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>		36. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>	
37. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>		38. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>		39. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>	
40. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>		41. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>		42. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>	
43. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>		44. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>		45. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>	
46. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>		47. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>		48. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>	
49. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>		50. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>		51. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>	
52. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>		53. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>		54. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>	
55. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>		56. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>		57. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>	
58. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>		59. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>		60. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>	
61. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>		62. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>		63. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>	
64. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>		65. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>		66. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>	
67. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>		68. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>		69. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>	
70. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>		71. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>		72. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>	
73. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>		74. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>		75. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>	
76. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>		77. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>		78. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>	
79. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>		80. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>		81. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>	
82. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>		83. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>		84. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>	
85. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>		86. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>		87. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>	
88. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>		89. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>		90. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>	
91. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>		92. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>		93. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>	
94. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>		95. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>		96. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>	
97. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>		98. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>		99. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>	
100. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>		101. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>		102. SIGNATURE OF JAILER'S DEPUTY <i>John Doe</i>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11529

Reg. Dist. No.

11580

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
c. LENGTH OF STAY IN 1b <u>20 yrs</u>				d. STREET ADDRESS <u>9625 Alta Vista Terrace</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9625 Alta Vista Terrace</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Ethel Mary Dorsey</u>				4. DATE OF DEATH <u>Oct 22 1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>August 13, 1894</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR <u>2</u> Months <u>9</u> Days <u>9</u> Hours <u>Min.</u>		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerical</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Contracting</u>			
11. BIRTHPLACE (State or foreign country) <u>N. J.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>			
13. FATHER'S NAME <u>Bodmer</u>				14. MOTHER'S MAIDEN NAME <u>A. Walsh</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>574-24-2775</u>			
17. INFORMANT <u>Frank E. Dorsey - Son - Item #2</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>(1) Acute myocardial insufficiency</u> DUE TO (b) <u>(2) Coronary occlusion</u> DUE TO (c) <u>(3) hemorrhage into atheromateous plaque</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHE</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>10-24-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>	
22d. LOCATION (City, town, or county) <u>Silver Spring, Maryland</u>				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>				ADDRESS			
24a. REC'D BY REGISTRAR <u>OCT 26 '59</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Give Page 4 to the funeral director. Give Page 5 to the Chief Medical Examiner's Office along with form PM3. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

11530

11506

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>47X-3</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1413 Floral St. N.W.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hosp.</u>		d. STREET ADDRESS <u>D.C.</u>	
3. NAME OF DECEASED (Type or print) <u>ANNA</u> First Middle Last <u>DOUGHTY</u>		4. DATE OF DEATH Month <u>OCT.</u> Day <u>6</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/1/76</u>
9. AGE (In years lost birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Switzerland</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>?</u> INFORMANT <u>Hospital Records</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac failure</u> <u>442X</u> DUE TO (b) <u>Cardio Vascular - Renal Disease Sev. Gr</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Arteriosclerosis - generalized.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 1959</u> to <u>Oct 6, 1959</u> that I last saw the deceased alive on <u>Oct 5, 1959</u> , and that death occurred at <u>1:45 PM</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>6950 Pines Branch Rd. NW</u> DATE SIGNED <u>10/6/59</u>			
ACTUAL SIGNATURE <u>W. WOOD HEIGES</u> M.D.		DATE SIGNED <u>10/6/59</u>	
PHYSICIAN'S NAME (Type) <u>W. WOOD HEIGES, M.D.</u>		DATE SIGNED <u>10/6/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>10/9/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co. - 2901-1428/77</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>OCT 8 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

HOSPITAL [REDACTED] **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATEMENT OF DEATH

11530

11530

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11531

11581

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1400 Brygs-Chaney Rd. Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring	
c. LENGTH OF STAY IN 1b 3 mo		d. STREET ADDRESS 1400 Brygs-Chaney Rd	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Eva Middle Willet Last Dowd		DATE OF DEATH Month 10 Day 9 Year 1959	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-4-1875
9. AGE (In years, months, and days) 84		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME THOMAS WILLETT		14. MOTHER'S MAIDEN NAME PHOEBE BRANGHT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Mrs Dorothy Chandler		Address 1400 Brygs-Chaney Rd Silver Spring	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stenocardia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 8 days DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Osteoarthritis of Spine			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/5/59 to 10/9/59 , that I last saw the deceased alive on 10/5/59 , and that death occurred at 9:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE C. H. Ligon		DATE SIGNED 10/9/59	
PHYSICIAN'S NAME (Type) C. H. Ligon		ADDRESS (Street, city or town, state) Sandy Spring, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) 10/14/59		22b. DATE THEREOF 10/14/59	
22c. NAME OF CEMETERY OR CREMATORY GRACELAND		22d. LOCATION (City, town, or county) (State) SIoux City IOWA	
23. FUNERAL DIRECTOR'S SIGNATURE Lee FUNERAL Home		ADDRESS 4th St NE	
24a. REC'D BY REGISTRAR DATE OCT 15 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

11582

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE _____ b. COUNTY <u>Washington, D. C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>4 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Congressional Manor</u>		d. STREET ADDRESS <u>3200 - 16th. St., N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>J.</u> Last <u>Drew</u>		4. DATE OF DEATH Month <u>10</u> Day <u>5</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 29 1873</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>6</u> Hours <u>6</u> Min. <u>6</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Principal of High Sch.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>SAN FRANCISCO, CALIF.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John R. DREW</u>		14. MOTHER'S MAIDEN NAME <u>KATHERINE ROCHE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Mrs. George F. Hallgarten-daughter</u>		Address <u>Item #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>332x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>3 yrs</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cancer of the Prostate & recurrent urinary tract infection</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>55</u> , to <u>Oct</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10/5</u> , 19 <u>59</u> , and that death occurred at <u>9:20 p.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Maurice Franks</u> M.D. <u>901 - 20th. St., N.W.</u> <u>10-5-59</u> PHYSICIAN'S NAME (Type) <u>Maurice Franks, M.D.</u> <u>Washington, D. C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-7-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>DATE OCT 7 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5019

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 14 Film G251 11-2-59 et

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elm Echo</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick (rural)</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9 Bryn Mar Ave.</u>				d. STREET ADDRESS <u>RFD #4</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Beulah Mae Fagan</u>				4. DATE OF DEATH Month Day Year <u>Oct 24 1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-2-1894</u>	
9. AGE (In years last birthday) <u>65 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W. Dr.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm Luther Ammonette</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>John A Fagan</u> Address <u>721 Dist Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>years</u>				INTERVAL BETWEEN ONSET AND DEATH <u>months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CVA about 1 1/2 yrs ago</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>10-24-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/26/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Linnaea Cyn.</u>		22d. LOCATION (City, town, or county) (State) <u>Linnaea, Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cherry Chase Funeral Home</u>				ADDRESS <u>5100 Wisconsin</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 28 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Robert S. Hume</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

CERTIFICATE OF DEATH

Reg. Dist. No.

11534

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Philomina Rest Home</u>		d. STREET ADDRESS <u>4018 S. Capitol St. SE</u>	
3. NAME OF DECEASED (Type or print) <u>Kathleen</u> First <u>W. Fairall</u> Middle <u>W.</u> Last		4. DATE OF DEATH <u>Oct 1 1959</u> Month <u>Oct</u> Day <u>1</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/24/1905</u>
9. AGE (In years last birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Health Research</u>	
11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas Whalen</u>		14. MOTHER'S MAIDEN NAME <u>Mary Hines</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Nursing Home Resident</u>	
17. INFORMANT <u>Nursing Home Resident</u>		Address <u>St. Philomina's Rest Home 14901 G.C. Ave. Rockville</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>345x Dehydration</u> DUE TO <u>Multiple Sclerosis</u> (b) <u></u> DUE TO <u></u> (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>YRS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>9/7</u> , 19 <u>59</u> , to <u>10/1</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9/28</u> , 19 <u>59</u> , and that death occurred at <u>7:35 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. H. Higgin</u>		ADDRESS (Street, city or town, state) <u>Sandy Spring, Md.</u>	
PHYSICIAN'S NAME (Type) <u>C. H. Higgin</u>		DATE SIGNED <u>10/1/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial 10-5-59</u>	<u>10-5-59</u>	<u>Ardenwood Mt. 2x in Green, Va</u>	<u>Ardenwood Mt. 2x in Green, Va</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Mettling</u>		24a. REC'D BY REGISTRAR <u>Arthur E. Thomas</u>	
ADDRESS <u>131 W. 1st St. Wash. D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Thomas</u>	
DATE <u>OCT 2 '59</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11507

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>3 wks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. San & Hosp</u>				e. STREET ADDRESS <u>8401 11th Ave</u>			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Fannie</u> Middle <u>Maude</u> Last <u>Ferrell</u>				4. DATE OF DEATH Month <u>10</u> Day <u>3</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-1-1873</u>	9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>			
11. BIRTHPLACE (State or foreign country) <u>Missouri</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>James L. Nensell</u>				14. MOTHER'S MAIDEN NAME <u>Martha Ferrell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>no</u>			
17. INFORMANT <u>From Patients chart</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> {myocardial degeneration <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of left hip Sept 8-59</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Accident, fell in room</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>9-8</u> 19 <u>59</u> p. m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>				20f. (City or town) (County) (State) <u>Silver Spring Montgomery Md</u>			
21. I certify that I attended the deceased from <u>Mar</u> , 19 <u>59</u> , to <u>Oct 3</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Oct 3</u> , 19 <u>59</u> , and that death occurred at <u>11:25 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John N. Andrews</u>				ADDRESS (Street, city or town, state) <u>9601 Colosville Rd</u>			
DATE SIGNED <u>10-3-59</u>							
PHYSICIAN'S NAME (Type) <u>John N. Andrews</u>				<u>Silver Spring Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>				22b. DATE THEREOF <u>10/6/59</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Bartow, Florida</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. Hines Co.</u>				ADDRESS <u>2901-14th St NW</u> <u>Wash. D. C.</u>			
24a. REC'D BY REGISTRAR <u>DATE OCT 6 59</u>				24b. REGISTRAR'S SIGNATURE <u>Orlando E. Hines</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11507

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

County of Suffolk State of Massachusetts

I, John J. Connelley, Registrar of the County of Suffolk, State of Massachusetts, do hereby certify that

John J. Connelley, of the County of Suffolk, State of Massachusetts, was born on March 10, 1885, at Weymouth, in the County of Suffolk, State of Massachusetts.

He died on March 10, 1957, at Weymouth, in the County of Suffolk, State of Massachusetts, at the age of 72 years.

His death was caused by arteriosclerosis of the heart and brain.

He was buried on March 12, 1957, at Weymouth, in the County of Suffolk, State of Massachusetts.

Witness my hand and the seal of the County of Suffolk, State of Massachusetts, this 10th day of March, 1957.

John J. Connelley
Registrar of the County of Suffolk, State of Massachusetts

John J. Connelley
Registrar of the County of Suffolk, State of Massachusetts

John J. Connelley
Registrar of the County of Suffolk, State of Massachusetts

John J. Connelley
Registrar of the County of Suffolk, State of Massachusetts

11585

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		c. LENGTH OF STAY IN 1b <u>23 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carbury Methodist Home</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARGARET</u> First Middle Last				4. DATE OF DEATH Month <u>10</u> Day <u>5</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 15 - 1870</u>		9. AGE (In years last birthday) <u>88</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Woodman Home</u>		11. BIRTHPLACE (State or foreign country) <u>Augusta Ga</u>		12. CITIZEN OF WHAT COUNTRY? <u>USC</u>	
13. FATHER'S NAME <u>George Caloun Fifer</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Pfeiffer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Abey Home Records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of head of pancreas</u> 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
21. I certify that I attended the deceased from <u>12-12</u> , 19 <u>59</u> , to <u>10-5</u> , 19 <u>59</u> that I last saw the deceased alive on <u>Oct 4</u> , 19 <u>59</u> , and that death occurred at <u>9:40</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Sarah E. Glover</u> M.D. <u>10/28 Cedar Lane Kensington, Md</u> <u>10-5-59</u> PHYSICIAN'S NAME (Type) <u>Sarah E. Glover</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-7-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>		22d. LOCATION (City, town, or county) (State) <u>Gaithersburg. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner. Gaithersburg. Md.</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>OCT 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Kress</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, or in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11537

11586

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 64 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE South Carolina b. COUNTY 77x-3 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parris Island d. STREET ADDRESS Box 644 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Richard Edwin FILLBACH		4. DATE OF DEATH Month Day Year October 7 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-7-22
9. AGE (In years last birthday) 37 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S.A.F.		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
11. BIRTHPLACE (State or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George FILLBACH		14. MOTHER'S MAIDEN NAME Ann BRENNAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW II		16. SOCIAL SECURITY NO. INFORMANT (Wife) Mary Fillbach	
17. ADDRESS Same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY FAILURE 200.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) APLASTIC BONE MARROW (c) RETICULUM CELL SARCOMA, PRIMARY BONE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE			
INTERVAL BETWEEN ONSET AND DEATH 24 HOURS 2 WEEKS 20 MOS.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NONE		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4 August 1959 to 7 October 1959 that I last saw the deceased alive on 7 October 1959 , and that death occurred at 3:10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda Md. 10-7-59 ACTUAL SIGNATURE G.B. Townsend M.D. U.S. Naval Hospital, Bethesda Md. PHYSICIAN'S NAME (Type) G.B. TOWNSEND LT MC USN U.S. Naval Hospital, Bethesda Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-13-59	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. PUMPHREY		24a. REC'D BY REGISTRAR 13 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11538

11587

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 14914-CRESCENT ST.	
3. NAME OF DECEASED (Type or print) CATHERINE First FRANCES Middle FITZGERALD Last		4. DATE OF DEATH Month 10 Day 13 Year 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB 23RD, 1899
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) WASHINGTON DC		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES FRANCIS KELLEY		14. MOTHER'S MAIDEN NAME CATHERINE FALVEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT HELEN O'BRIEN Address 1228-BUCHANAN ST. N.E.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral arteriosclerosis DUE TO (c) Diabetes mellitus			INTERVAL BETWEEN ONSET AND DEATH 5 1/2 Unknown 1936
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept , 19 54 , to Oct , 19 57 , that I last saw the deceased alive on Oct 13 , 19 59 , and that death occurred at 7:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Francis J. Murray M.D. 2111 Bancroft Pl. NW		ADDRESS (Street, city or town, state) Wash. D.C. DATE SIGNED 10/13/59	
PHYSICIAN'S NAME (Type) FRANCIS J. MURRAY		Wash. D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		10/17/59	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
St. Clare's		Wash. D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Anthony A. ...		24a. REC'D BY REGISTRAR DATE OCT 21 '59	
ADDRESS 3831 ...		24b. REGISTRAR'S SIGNATURE ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

NAME OF DECEASED

AGE

SEX

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Burial Officer

Signature of Undertaker

Signature of Minister of the Gospel

Signature of Interment Officer

Signature of Cemetery Officer

Signature of Health Officer

Signature of Medical Examiner

Signature of Pathologist

Signature of Anatomist

Signature of Surgeon

Signature of Dentist

Signature of Apothecary

Signature of Dispensing Surgeon

Signature of Medical Officer of Health

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11539

11588

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville Bethesda				c. LENGTH OF STAY IN 1b 1 Hr. 20 Min. 26			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban				d. STREET ADDRESS 309 Howard Ave.			
3. NAME OF DECEASED (Type or print) First Amos Middle Walker Last Flanary				4. DATE OF DEATH Month Oct. Day 17 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1903	
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months 56 Days 56 Hours 56 Min. 56		IF UNDER 24 HRS. Months 56 Days 56 Hours 56 Min. 56			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James Flanary				14. MOTHER'S MAIDEN NAME Mary Lawson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mrs. Annie Flanary Address 309 Howard Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage & laceration 976x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bullet wound Thru skull DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted bullet wound			
20c. TIME OF INJURY Month, Day, Year Hour 10-15 P. M. 10-16 19 59				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) Rockville Monty				20g. (County) md		20h. (State) md	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschatt M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) FRANK J. Broschatt				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 10-17-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit		22b. DATE THEREOF 10/22/59		22c. NAME OF CEMETERY OR CREMATORY Millers Chapel		22d. LOCATION (City, town, or county) (State) Pennington Grove, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR Oct 20 1959	
				24b. REGISTRAR'S SIGNATURE William S. Hume			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

10

CERTIFICATE OF DEATH

11540

Reg. Dist. No.

11589

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 19 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE North Carolina b. COUNTY Greensboro c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 70x-3 d. STREET ADDRESS 1110 Bellevue Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First Middle Last Blanche Estelle Fogleman		4. DATE OF DEATH Month Day Year October 16, 1959		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 13, 1905		9. AGE (In years lost birthday) yrs. 54		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None				11. BIRTHPLACE (State or foreign country) North Carolina				12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Hugh Thomas Ryder				14. MOTHER'S MAIDEN NAME Pamela Caroline Staley				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None				INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation secondary to Progressive Cardiac Failure. DUE TO (b) Closure of Atrio-Ventricular Canal Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Congenital Heart Disease														INTERVAL BETWEEN ONSET AND DEATH Immediate 3 days Birth					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from September 27, 1959 to October 16, 1959 , that I last saw the deceased alive on October 16, 1959 , and that death occurred at 7:40 P.M. from the causes and on the date stated above. 6:40 p.m. ADDRESS (Street, city or town, state) The Clinical Center 10-17-59 DATE SIGNED ACTUAL SIGNATURE Robert A. Pumphrey M.D. National Institutes of Health PHYSICIAN'S NAME (Type) LAZAR GREENFIELD, M.D. Bethesda 14, Maryland																			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 10-17-59				22b. DATE THEREOF 10-17-59				22c. NAME OF CEMETERY OR CREMATORY Forest Lawn Cem.				22d. LOCATION (City, town, or county) (State) Guilford County, No. Car.							
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY Address Bethesda, Md.								24a. REC'D BY REGISTRAR DATE OCT 20 1959				24b. REGISTRAR'S SIGNATURE Arthur S. Hume							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2200 • J. Neurosci., September 24, 2008 • 28(39):2195–2200

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

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600K

Course of Action

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
c. LENGTH OF STAY IN 1b 3 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 210 Baltimore Road		d. STREET ADDRESS 210 Baltimore Road	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JENNIE Middle M. Last FREEMAN		4. DATE OF DEATH Month October Day 6 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 3, 1881
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR: Months 2 Days 3 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) New York
		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
		17. INFORMANT Daughter-in-law Address Mrs. Maxwell M. Freeman - Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIAL HYPERTENSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c) CORONARY THROMBOSIS			INTERVAL BETWEEN ONSET AND DEATH 20 YEARS 20 YEARS 7 DAYS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PARTIAL SINUS			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from September 28, 1959 , to October 6, 1959 , that I last saw the deceased alive on October 6, 1959 , and that death occurred at 5 P. M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Gordon S. Rosenberg		ADDRESS (Street, city or town, state) 26th Summit Ave DATE SIGNED 6 Oct 1959	
PHYSICIAN'S NAME (Type) Gordon S. Rosenberg		GAITHERSBURG, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur. Trans.	22b. DATE THEREOF 10-9-59	22c. NAME OF CEMETERY OR CREMATORY Fern Hill Cemetery	22d. LOCATION (City, town, or county) (State) Stuart, Florida
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE OCT 13 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No. 215

11590

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 50 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.				d. STREET ADDRESS 501 Seward St. S.E.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Margaret Middle J Last FREEMAN				4. DATE OF DEATH Month October Day 2 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-11-15	
9. AGE (In years lost birthday) 44 yrs.		10. IF UNDER 1 YEAR Months 44 Days 44 Hours 44 Min.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None			
13. FATHER'S NAME William N. ELLIS				14. MOTHER'S MAIDEN NAME Maggie DEALVEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Hospital records			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infection of Myocardium 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diabetes Mellitus DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH 20 MIN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Date nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 13 August, 1959 to 2 October, 1959 that I last saw the deceased alive on 2 October, 1959 , and that death occurred at 8:00AM from the causes and on the date stated above.							
ACTUAL SIGNATURE R. G. Muth				ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md. DATE SIGNED 10-2-59			
PHYSICIAN'S NAME (Type) R. G. MUTH LT MC USN				U.S. Naval Hospital, Bethesda Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-5-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Mattingly				24a. REC'D BY REGISTRAR OCT 7 '59			
ADDRESS Mattingly 131 11th Street S.E. Washington D.C.				24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1153

1153

Director of Columbia

Director of Columbia

Estimate (Pupils) 20 days

Washington

U.S. Naval Hospital, Bethesda Md. 201 Howard St. S.E.

THOMAS

Manager

6-11-15

Female White

U.S.

Married

Home

Married

Married

Married

Hospital records

No

1

13 August 1915

8:00 AM

U.S. Naval Hospital, Bethesda Md.

10-2-30

U.S. Naval Hospital, Bethesda Md.

Washington D.C.

Washington D.C.

11591

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norbeck		c. LENGTH OF STAY IN lb 3 hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sewell's Maternity Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Male Baby		4. DATE OF DEATH Oct. 21 1959	
5. SEX male	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 21, 59
9. AGE (In years last birthday) 0		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) foetus		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Norbeck Rt.1 Silv.Sp.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Leslie I. Gaines		14. MOTHER'S MAIDEN NAME L. Bernice Stewart	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT mother Sandy Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. Preeclamptic Toxemia in mother noticed Oct. 7 769.0 DUE TO 2. Cord about neck twice around. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 3. Prolonged Labor Oct. 18 a.m. to Oct. 21 DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mother Diabetic; age 41.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Autopsy report from Suburban Hospital	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct. 21 12:05 a.m. to 3:30 a.m. last saw the deceased alive on Oct. 21 59 , 19____, and that death occurred at 3:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 10.22.59			
ACTUAL SIGNATURE Webster Sewell M.D.		10.22.59	
PHYSICIAN'S NAME (Type) Webster Sewell, M.D. Norbeck, Rt.1 Silver Spring, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/23/59	22c. NAME OF CEMETERY OR CREMATORY Ash Memorial,	22d. LOCATION (City, town, or county) (State) Sandy Spring, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Sander ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR DATE OCT 27 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kinn

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VS A15 (4)
15M 9/58

2094415XV4

CERTIFICATE OF DEATH

11591

No. 120000

Birthdate

3 years

Ready Spring, N.Y.

Death's Information: Date of Death, Nov. 1, 1918

Time

Between 7 and 8

Oct. 31

Location

Section 1, Grave

Funeral Home, Ready Spring, N.Y.

- 1. Burial in Ready Spring, N.Y.
- 2. Date of Burial, Nov. 1, 1918
- 3. Burial in Ready Spring, N.Y.

Death Certificate No. 11591

Ready Spring, N.Y.

Nov. 1, 1918

Ready Spring, N.Y.

Ready Spring, N.Y.

Nov. 1, 1918

Ready Spring, N.Y.

Ready Spring, N.Y.

Ready Spring, N.Y.

11508

CERTIFICATE OF DEATH

Reg. Dist. No. 11544

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. State Hosp. Takoma Park, Md.</u>				d. STREET ADDRESS <u>560 Silver Springs</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>D'Arcy Gerald Gallagher</u>				4. DATE OF DEATH Month Day Year <u>Oct. 25 1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-1-1916</u>	9. AGE (In years last birthday) <u>43</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Army Ordnance - Dist. (supervisor)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Canada N.Y.</u>		11. BIRTHPLACE (State or foreign country) <u>Canada N.Y.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>America</u>							
13. FATHER'S NAME <u>John Gallagher</u>				14. MOTHER'S MAIDEN NAME <u>Frances O'Neill</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>YES WORLD WAR II</u>				16. SOCIAL SECURITY NO. <u>Hospital Chart</u>		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction, postural</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary atherosclerosis</u> DUE TO (c) <u>15 days</u> <u>2 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from <u>8-14</u> , 19 <u>59</u> , to <u>10-25</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10-24</u> , 19 <u>59</u> , and that death occurred at <u>1:05 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>929 Plunking Ave</u> <u>10-25-59</u>							
ACTUAL SIGNATURE <u>Sergeant T. Kunkle</u>				PHYSICIAN'S NAME (Type) <u>Silver Spring, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Oct. 29, 1959</u>		<u>ARLINGTON NATL</u>		<u>ARLINGTON VA.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Warren Taltavall</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 28 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

80215

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 4 mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4503 Traymore Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Louise Last Gallahorn		4. DATE OF DEATH Month 10/17 Day 19 Year 59	
5. SEX F	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 16, 1875
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months 83 Days 83 Hours 83 Min.	IF UNDER 24 HRS. Months 83 Days 83 Hours 83 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Alexandria, Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
3. FATHER'S NAME Charles R. Brill		14. MOTHER'S MAIDEN NAME Elizabeth Louise Niter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT James T. Gallahorn, Jr.		Address Bethesda, Md. 4503 Traymore St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma Cervix Uteri - 5 year			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 15 , 19 51 , to Oct 16 , 19 59 , that I last saw the deceased alive on Oct 14 , 19 59 , and that death occurred at 1045 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1714 R. J. Ave NW Washington D.C. DATE SIGNED OCT 20 '59			
ACTUAL SIGNATURE Arthur H. Lewis		M.D. 1714 R. J. Ave NW Washington D.C.	
PHYSICIAN'S NAME (Type) ARTHUR H. LEWIS		Washington D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 10/20/59	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		24a. REC'D BY REGISTRAR OCT 20 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines		24c. DATE OCT 20 '59	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1193

Bartholomew

Bartholomew

Bartholomew

Bartholomew

Bartholomew

Bartholomew Street

Bartholomew Street

Bartholomew

Bartholomew

10/17

Bartholomew

Bartholomew

Bartholomew, Virginia

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Bartholomew

Bartholomew

Bartholomew

Bartholomew

none

no

Bartholomew

Bartholomew

Bartholomew

Bartholomew

Bartholomew

Bartholomew

Bartholomew

Bartholomew

Bartholomew

Bartholomew

Bartholomew

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11546

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4619 Highland Street			d. STREET ADDRESS 4619 Highland Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First James Middle Garrioch Last Garrioch			4. DATE OF DEATH Month October Day 15 Year 1959		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 7, 1865		9. AGE (In years last birthday) 94 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Gardner		11. BIRTHPLACE (State or foreign country) Scotland	12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME Charles Garrioch			14. MOTHER'S MAIDEN NAME Margaret Doldly		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Rebecca Garrioch-wife-same as 2d	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH sudden					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE Frank J. Broschart M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED
EXAMINER'S NAME (Type) Frank J. Broschart			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		10/15/59
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/17/59		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery	
				22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey			ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE OCT 16 '59
					24b. REGISTRAR'S SIGNATURE Arthur S. Kline

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	
AGE _____		DATE OF BIRTH _____	
PLACE OF BIRTH _____		OCCUPATION _____	
MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		DATE OF MARRIAGE _____	
NAME OF SPOUSE _____		NAME OF CHILD(REN) _____	
STREET ADDRESS _____		CITY AND STATE _____	
ZIP CODE _____		COUNTY _____	
DECEASED AT HOME <input type="checkbox"/> Yes <input type="checkbox"/> No		PLACE OF DEATH _____	
CAUSE OF DEATH _____		MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined	
MEDICAL HISTORY _____		PRESENT ILLNESS _____	
PHYSICIAN'S SIGNATURE _____		MEDICAL EXAMINER'S SIGNATURE _____	
DATE OF EXAMINATION _____		TIME OF EXAMINATION _____	

CERTIFICATE OF DEATH

Reg. Dist. No.

11547

11594

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4773 Bradley Blvd.		d. STREET ADDRESS 4773 Bradley Blvd.	
3. NAME OF DECEASED (Type or print) First ALMA Middle B. Last GATEWOOD		4. DATE OF DEATH Month October 28, Day 19 Year 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 6, 1905
9. AGE (In years, low birthday) 54 yrs.		10. IF UNDER 1 YEAR Months 9 Days 22	
11. IF UNDER 24 HRS. Hours 1 Min. 15		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Leo F. Zwissler		14. MOTHER'S MAIDEN NAME Emma Schneider	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT W. Frank Gatewood - Husband - Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma 175.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Primary Carcinoma - OVARY DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 Mo 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 28, 1959 to Oct 28, 1959 , that I last saw the deceased alive on Oct 28, 1959 , and that death occurred at 8:57 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Leo I Donovan M.D.		DATE SIGNED Nov 2 1959	
PHYSICIAN'S NAME (Type) LEO I DONOVAN M.D.		ADDRESS (Street, city or town, state) Bethesda, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-31-59	22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery	22d. LOCATION (City, town, or county) (State) Rockville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		24. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11594

CERTIFICATE OF NATALITY

11594

NOTARY

IN WITNESS WHEREOF

I have hereunto set my hand and seal

at the City of New York

this 11th day of May

1900

Notary Public

My Commission Expires

on the 11th day of May

1901

at New York

Witness my hand and seal

this 11th day of May

1900

at New York

My Commission Expires

on the 11th day of May

1901

at New York

Witness my hand and seal

this 11th day of May

1900

at New York

My Commission Expires

on the 11th day of May

1901

at New York

Witness my hand and seal

this 11th day of May

1900

at New York

My Commission Expires

on the 11th day of May

1901

at New York

Witness my hand and seal

this 11th day of May

1900

at New York

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11535

Reg. Dist. No. 11548

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville c. LENGTH OF STAY IN 1b MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Wheaton, Silver Spring		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) E. Montg. Ave. & Bridge St.			d. STREET ADDRESS 1708 Arcola Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) GEORGE RAYMOND GIBSON			4. DATE OF DEATH Month Oct. Day 5, Year 1959		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 31, 1885	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Builder		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? US					
13. FATHER'S NAME George Gibson			14. MOTHER'S MAIDEN NAME Virginia Hinton		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 578-03-1063		17. INFORMANT Address Mrs Janie E. Gibson-Item# 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH sudden					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Frank J. Broschart		EXAMINER'S NAME (Type) Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 10-5-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/8/59		22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY	
22d. LOCATION (City, town, or county) PRINCE GEO. COUNTY, MARYLAND					
23. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska		ADDRESS WARNER E. PUMPHREY, INC. SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE OCT 7 '59	
				24b. REGISTRAR'S SIGNATURE Arthur & Kraus	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1
1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11509
CERTIFICATE OF DEATH

Reg. Dist. No. 11549

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sant + Hospt.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Charlotte Beatrice Goodwin</i>		4. DATE OF DEATH Month <i>Oct.</i> Day <i>24</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-2-93</i>
9. AGE (In years last birthday) <i>65</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>N. Y.</i>		12. CITIZEN OF WHAT COUNTRY? <i>America</i>	
13. FATHER'S NAME <i>Philip Farron</i>		14. MOTHER'S MAIDEN NAME <i>Esther Abrams</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Patient's Chart.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ventricular Fibrillation—Terminal</i> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Cardiovascular Disease with Congestive Heart Failure</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>10 min</i> <i>about 4 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes Mellitus</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>JUNE</i> , 1954, to <i>OCT 24</i> , 1959, that I last saw the deceased alive on <i>OCT 24</i> , 1959, and that death occurred at <i>630 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Robert L. Krichmar</i>		DATE SIGNED <i>OCT 24 1959</i>	
PHYSICIAN'S NAME (Type) <i>ROBERT L. KRICHMAR M.D.</i>		ADDRESS (Street, city or town, state) <i>7733 ALASKA AVE NW WASH 12 DC</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>OCT. 26, 1959</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>KILYB DAVID MEM. GARDEN</i>		22d. LOCATION (City, town, or county) (State) <i>FALLS CHURCH VA.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>B. Danyensky & Sons</i>		ADDRESS <i>3501-14 St. N.W.</i>	
24a. REC'D BY REGISTRAR <i>DATE OCT 28 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

11540

CERTIFICATE OF DEATH

11509

WITNESSES

11509

11509

11595

CERTIFICATE OF DEATH

Reg. Dist. No.

11550

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. LENGTH OF STAY IN 1b 7 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL				/ d. STREET ADDRESS Rt. #3			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JOSEPH Middle BRAKTON Last GRAY			4. DATE OF DEATH Month OCTOBER Day 8 Year 19 59				
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/10/71		9. AGE (In years lost birthday) 88 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Bushrod Gray				14. MOTHER'S MAIDEN NAME Martha Kelly			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		INFORMANT HOSPITAL RECORDS		
					Address OLNEY, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BILATERAL BRONCHOPNEUMONIA 500 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ACUTE TRACHEOBRONCHITIS DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE INTERVAL BETWEEN ONSET AND DEATH 8 days 8 days years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10-1-1959 , to 10-8-1959 , that I last saw the deceased alive on Oct-7-1959 , and that death occurred at 2:30 A. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Gaithersburg, Md DATE SIGNED							
ACTUAL SIGNATURE W. C. Miller			M.D. Gaithersburg, Md				
PHYSICIAN'S NAME (Type) W. C. MILLER, M. D.			GAITHERSBURG, MARYLAND				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-10-59		22c. NAME OF CEMETERY OR CREMATORY Monocacy		22d. LOCATION (City, town, or county) (State) Beallsville. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner. Gaithersburg. Md.				24a. REC'D BY REGISTRAR DATE OCT 13 '59		24b. REGISTRAR'S SIGNATURE Arthur B. Kline	

MONTGOMERY

MONTGOMERY

MONTGOMERY

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WATKINS

WATKINS

MONTGOMERY COUNTY GENERAL HOSPITAL

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11596

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE South Carolina b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 10 days		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.			d. STREET ADDRESS Route 1		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Jean Middle Carroll Last Gregory			4. DATE OF DEATH Month October Day 7 Year 1959		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 4, 1934		9. AGE (In years last birthday) 25 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher		10b. KIND OF BUSINESS OR INDUSTRY Education	11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Albert A. Gregory			14. MOTHER'S MAIDEN NAME Mattie Bailey		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unascertainable		INFORMANT The Medical Record, Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congenital heart disease DUE TO status, postoperative (c)					INTERVAL BETWEEN ONSET AND DEATH 12 hours Life
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from September 27 1959 , to October 7, 1959 , that I last saw the deceased alive on October 7, 1959 and that death occurred at 6:40 A. from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>William W. Pfaff</i>		M.D. The Clinical Center		DATE SIGNED 10/7/59	
PHYSICIAN'S NAME (Type) William W. Pfaff, M.D.		National Institutes of Health		Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial - 10-7-59		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
				22d. LOCATION (City, town, or county) (State) Union, South Carolina	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i>		ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DATE OCT 13 '59	
				24b. REGISTRAR'S SIGNATURE <i>Arthur A. Evans</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

South Carolina

Postmortem

Jonestown

10 days

Postmortal

Route 1

The Clinical Center, Bethesda, Md.

Gregory

Control

John

October 7

August 1, 1934

Female

School Teacher

Honolulu

South Carolina

U.S.A.

Mattie Miller

Robert A. Gregory

The Medical Record

Unascertainable The Clinical Center, Bethesda, Md.

12 hours

Cardiac failure

Life

Congenital heart disease
status, postoperative

September 27 59 October 7 59

6:12 A

October 7 59

10/1/59

The Clinical Center
National Institutes of Health
Bethesda, Md., Maryland

William W. Kelly, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11552

11510

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park,				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adelphi			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium and Hosp.				d. STREET ADDRESS 10427 Tullymore Dr.,			
3. NAME OF DECEASED (Type or print) First Middle Last Grguras				4. DATE OF DEATH Month Day Year October 11, 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 10, 1959	
9. AGE (In years lost birthday) yrs. 13		IF UNDER 1 YEAR Months Days Hours Min. 13 -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? America	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) no				10b. KIND OF BUSINESS OR INDUSTRY no			
13. FATHER'S NAME Adolf Rudolf Grguras				14. MOTHER'S MAIDEN NAME Shirley Marie Aiken			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. no			
17. INFORMANT father				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) prematurity DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 13 hrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Oct 11 , 19 59 , to Oct 11 , 19 59 , that I last saw the deceased alive on Oct 11 , 19 59 , and that death occurred at 4p M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE James D. Brew, Jr. M.D. 1801 K St., N.W. Washington, D.C.				1801 K Street, N.W. Washington, D.C.			
PHYSICIAN'S NAME (Type) James D. Brew Jr., M.D.				1801 K Street, N.W. Washington, D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 10-12-59		22c. NAME OF CEMETERY OR CREMATORY Washington Sanitarium & Hospital, Takoma Park 12, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Hare, M. D. Washington Sanitarium and Hospital Takoma Park 12, Maryland				24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE			

OCT 21 '59

Arthur S. Hines

CERTIFICATE OF DEATH

11370

File No. 11370

1. NAME OF DECEASED JOHN J. BROWN		2. SEX Male		3. AGE 45	
4. DATE OF DEATH October 10, 1953		5. TIME OF DEATH 10:30 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Myocardial Infarction		8. MANNER OF DEATH Natural		9. PLACE OF BIRTH Baltimore, Md.	
10. DATE OF BIRTH September 15, 1908		11. PLACE OF BIRTH Baltimore, Md.		12. OCCUPATION Engineer	
13. MARITAL STATUS Married		14. NAME OF SPOUSE Elizabeth A. Brown		15. NAME OF PHYSICIAN Dr. J. H. Smith	
16. NAME OF FUNERAL HOME John J. Brown & Sons		17. NAME OF BURIAL PLACE Greenwood Cemetery		18. NAME OF MINISTER Rev. J. H. Smith	
19. NAME OF CORONER John J. Brown		20. NAME OF JURY None		21. NAME OF WITNESSES None	
22. NAME OF REGISTRAR John J. Brown		23. NAME OF CLERK John J. Brown		24. NAME OF ASSISTANT CLERK John J. Brown	
25. NAME OF DEPUTY CLERK John J. Brown		26. NAME OF DEPUTY CLERK John J. Brown		27. NAME OF DEPUTY CLERK John J. Brown	
28. NAME OF DEPUTY CLERK John J. Brown		29. NAME OF DEPUTY CLERK John J. Brown		30. NAME OF DEPUTY CLERK John J. Brown	
31. NAME OF DEPUTY CLERK John J. Brown		32. NAME OF DEPUTY CLERK John J. Brown		33. NAME OF DEPUTY CLERK John J. Brown	
34. NAME OF DEPUTY CLERK John J. Brown		35. NAME OF DEPUTY CLERK John J. Brown		36. NAME OF DEPUTY CLERK John J. Brown	
37. NAME OF DEPUTY CLERK John J. Brown		38. NAME OF DEPUTY CLERK John J. Brown		39. NAME OF DEPUTY CLERK John J. Brown	
40. NAME OF DEPUTY CLERK John J. Brown		41. NAME OF DEPUTY CLERK John J. Brown		42. NAME OF DEPUTY CLERK John J. Brown	
43. NAME OF DEPUTY CLERK John J. Brown		44. NAME OF DEPUTY CLERK John J. Brown		45. NAME OF DEPUTY CLERK John J. Brown	
46. NAME OF DEPUTY CLERK John J. Brown		47. NAME OF DEPUTY CLERK John J. Brown		48. NAME OF DEPUTY CLERK John J. Brown	
49. NAME OF DEPUTY CLERK John J. Brown		50. NAME OF DEPUTY CLERK John J. Brown		51. NAME OF DEPUTY CLERK John J. Brown	
52. NAME OF DEPUTY CLERK John J. Brown		53. NAME OF DEPUTY CLERK John J. Brown		54. NAME OF DEPUTY CLERK John J. Brown	
55. NAME OF DEPUTY CLERK John J. Brown		56. NAME OF DEPUTY CLERK John J. Brown		57. NAME OF DEPUTY CLERK John J. Brown	
58. NAME OF DEPUTY CLERK John J. Brown		59. NAME OF DEPUTY CLERK John J. Brown		60. NAME OF DEPUTY CLERK John J. Brown	
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64. NAME OF DEPUTY CLERK John J. Brown		65. NAME OF DEPUTY CLERK John J. Brown		66. NAME OF DEPUTY CLERK John J. Brown	
67. NAME OF DEPUTY CLERK John J. Brown		68. NAME OF DEPUTY CLERK John J. Brown		69. NAME OF DEPUTY CLERK John J. Brown	
70. NAME OF DEPUTY CLERK John J. Brown		71. NAME OF DEPUTY CLERK John J. Brown		72. NAME OF DEPUTY CLERK John J. Brown	
73. NAME OF DEPUTY CLERK John J. Brown		74. NAME OF DEPUTY CLERK John J. Brown		75. NAME OF DEPUTY CLERK John J. Brown	
76. NAME OF DEPUTY CLERK John J. Brown		77. NAME OF DEPUTY CLERK John J. Brown		78. NAME OF DEPUTY CLERK John J. Brown	
79. NAME OF DEPUTY CLERK John J. Brown		80. NAME OF DEPUTY CLERK John J. Brown		81. NAME OF DEPUTY CLERK John J. Brown	
82. NAME OF DEPUTY CLERK John J. Brown		83. NAME OF DEPUTY CLERK John J. Brown		84. NAME OF DEPUTY CLERK John J. Brown	
85. NAME OF DEPUTY CLERK John J. Brown		86. NAME OF DEPUTY CLERK John J. Brown		87. NAME OF DEPUTY CLERK John J. Brown	
88. NAME OF DEPUTY CLERK John J. Brown		89. NAME OF DEPUTY CLERK John J. Brown		90. NAME OF DEPUTY CLERK John J. Brown	
91. NAME OF DEPUTY CLERK John J. Brown		92. NAME OF DEPUTY CLERK John J. Brown		93. NAME OF DEPUTY CLERK John J. Brown	
94. NAME OF DEPUTY CLERK John J. Brown		95. NAME OF DEPUTY CLERK John J. Brown		96. NAME OF DEPUTY CLERK John J. Brown	
97. NAME OF DEPUTY CLERK John J. Brown		98. NAME OF DEPUTY CLERK John J. Brown		99. NAME OF DEPUTY CLERK John J. Brown	
100. NAME OF DEPUTY CLERK John J. Brown		101. NAME OF DEPUTY CLERK John J. Brown		102. NAME OF DEPUTY CLERK John J. Brown	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11597

CERTIFICATE OF DEATH

11553

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Laytonsville b. COUNTY Mont.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boys		c. LENGTH OF STAY IN 1b 2 wks.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Simpson Nursing Home		d. STREET ADDRESS Maryland	
3. NAME OF DECEASED (Type or print) First William Middle Waters Last Griffith		4. DATE OF DEATH Month Oct. Day 5 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 14, 1879
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY Gen. Construction	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Riggs Griffith		14. MOTHER'S MAIDEN NAME Isabel Griffith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. Unknown	
INFORMANT Mrs. Jessie M. Griffith		Address Same as 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart disease with failure DUE TO (c) Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 3 days 20 days 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3 Sept., 1959 to 5 Oct., 1959 , that I last saw the deceased alive on 5 Oct. 1959 , and that death occurred at 10:12 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Baynesville, Md. DATE SIGNED 5 Oct. 59 ACTUAL SIGNATURE John McSmith M.D. PHYSICIAN'S NAME (Type) John McSmith			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 8, 1959	22c. NAME OF CEMETERY OR CREMATORY Laytonsville Meth.	22d. LOCATION (City, town, or county) (State) Laytonsville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Clayton Barber		24a. REC'D BY REGISTRAR Oct 9 59 24b. REGISTRAR'S SIGNATURE Clayton Barber	

TO HOSPITAL—ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11553
CENTRAL DEPT. OF HEALTH
1957

DATE: MAY 14, 1957

LOCAL OFFICE

STATE DEPT. OF HEALTH

LOCAL OFFICE

STATE DEPT. OF HEALTH

LOCAL OFFICE

STATE DEPT. OF HEALTH

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1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G254 1-20-60 et

11598

CERTIFICATE OF DEATH

11554

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney	c. LENGTH OF STAY IN 1b 4 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover 16x-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) Montgomery County General Hospital, Inc.		d. STREET ADDRESS The Oaks, Ardnore, R.F.D.	
3. NAME OF DECEASED (Type or print) First Lula Middle Elizabeth Last Grosvenor		4. DATE OF DEATH Month 10 Day 2 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2.26.69/ 1879
9. AGE (In years lost birthday) yrs. 80		IF UNDER 1 YEAR Months 10 Days 2 Hours 19 Min. 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Stephen Pitts		14. MOTHER'S MAIDEN NAME Mary Elizabeth Sisson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO. No	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Carcinoma of Urinary Bladder DUE TO Carcinoma of Urinary Bladder (c) Carcinoma of Urinary Bladder PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchopneumonia			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9:25 , 19 59 , to 10:21 , 19 59 , that I last saw the deceased alive on 10/1 , 19 59 , and that death occurred at 4:05 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE J. W. Bird		DATE SIGNED 10/2/59	
PHYSICIAN'S NAME (Type) J. W. Bird, M. D.		ADDRESS (Street, city or town, state) Sandy Sping, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 5 59	22c. NAME OF CEMETERY OR CREMATORY National Memorial	22d. LOCATION (City, town, or county) (State) Falls Church Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Ray W. Barber		ADDRESS Laytonsville, Md	
24a. REC'D BY REGISTRAR OCT 6 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased JAMES J. JONES		Date of Death 1910	
Sex Male		Age 45	
Race White		Birthplace Baltimore, Md.	
Usual Residence 1000 North Avenue, Baltimore, Md.		Place of Death 1000 North Avenue, Baltimore, Md.	
Cause of Death Heart Disease		Date of Birth 1865	
Signature of Physician J. J. Jones		Signature of Registrar J. J. Jones	
Date of Report 1910		Date of Death 1910	

11599

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring		c. LENGTH OF STAY IN life life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Henry Hackett		4. DATE OF DEATH Month Oct. Day 26 Year 1959	
5. SEX male	6. COLOR OR RACE Col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 15, 1883
9. AGE (In years, months, days) 76		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Houseman		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Anna Hackett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Informant	
17. ADDRESS Estelle Hackett, Sandy Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive C.R.D. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1/2 hour June 58 1946
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arthritis. Raynaud's Syndrome.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 25 , 19 46 , to Oct. 26 , 19 59 , that I last saw the deceased alive on Oct. 24 , 19 59 and that death occurred at 2:15 A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Norbeck Rt. 1 Silver Spring, 10/29			
ACTUAL SIGNATURE Webster Sewell		M.D. Norbeck Rt. 1 Silver Spring, 10/29	
PHYSICIAN'S NAME (Type) Webster Sewell			
22a. BURIAL, CREMATION, or other disposition (Specify) Burial	22b. DATE THEREOF 10/30/59	22c. NAME OF CEMETERY OR CREMATORY Ash Memorial,	22d. LOCATION (City, town, or county) (State) Sandy Spring, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden		ADDRESS Rockville, Md.	
24a. REC'D BY REGISTRAR DATE NOV 2 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10702

CENTRAL CASE OF DATA

11702

11702

1

CERTIFICATE OF DEATH

Reg. Dist. No.

11556

11600

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Pennsylvania b. COUNTY Lancaster			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lancaster			
c. LENGTH OF STAY IN 1b 84 days				d. STREET ADDRESS 30 North Eastland Drive			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Robert Middle Harry Last Hall			4. DATE OF DEATH Month October Day 2 Year 1959				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 4, 1948		9. AGE (In years last birthday) 10 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student			10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Robert T. Hall			14. MOTHER'S MAIDEN NAME Esther Greenswalt				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT The Medical Record, Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhagic pneumonia 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Leukemia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 3 days 1 year
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 10, 1959 , to October 2, 1959 , that I last saw the deceased alive on October 2, 1959 , and that death occurred at 6:50 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center Bethesda 14, Maryland DATE SIGNED 10/2/59							
ACTUAL SIGNATURE Charles E. Mengel M.D.				PHYSICIAN'S NAME (Type) Charles E. Mengel, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/5/59		22c. NAME OF CEMETERY OR CREMATORY Strasburg Menno.Cem.		22d. LOCATION (City, town, or county) (State) Strasburg, Lanc.Co., Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Ruth M. Young ADDRESS 317 E. Orange St. Lancaster, Pa.				24a. REC'D BY REGISTRAR OCT 8 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Knaus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Montgomery	
Residence		Bl. Ave.	
Place of Death		The Clinical Center, Baltimore 12, Md.	
Date of Death		October 2, 1952	
Time of Death		11:00 A.M.	
Cause of Death		White	
Sex		Male	
Age		20	
Occupation		Student	
Marital Status		Single	
Place of Birth		Baltimore, Md.	
Date of Birth		October 1, 1932	
Father's Name		The Clinical Center, Baltimore 12, Maryland	
Mother's Name		The Clinical Center, Baltimore 12, Maryland	
Immediate Cause of Death		Acute leukemia	
Underlying Cause of Death		Chronic leukemia	
Duration of Illness		1 year	
Date of Admission to Hospital		October 2, 1952	
Date of Discharge from Hospital		October 2, 1952	
Date of Death		October 2, 1952	
Time of Death		11:00 A.M.	
Place of Death		The Clinical Center, Baltimore 12, Maryland	
Signature of Physician		Charles E. Jorgel, M.D.	
Signature of Registrar		The Clinical Center	
Date of Registration		October 2, 1952	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11557

11601

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>26</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>1004 Lewis Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Ostrid</u> First <u>M. Hammarborg</u> Middle <u>M.</u> Last <u>Hammarborg</u>		4. DATE OF DEATH <u>10</u> <u>14</u> <u>1959</u> Month Day Year	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 27, 1907</u> 32 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Research Analyst Nat'l. Sec. Agency</u>		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>	
13. FATHER'S NAME <u>Emil John Hammarborg</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <u>yes</u> (Yes, no, or unknown) (If yes, give year or years of service) <u>WAC</u>		16. SOCIAL SECURITY NO. <u>342-18-4188</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GENERALIZED CARCINOMATOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CARCINOMA OF STOMACH-LIMPH PLASTIC</u> DUE TO (c) <u>2 1/2 YRS.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 YRS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Brother - Frith of C. Hammarborg</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3/14/54</u> , 19 <u>54</u> , to <u>10/14/59</u> , that I last saw the deceased alive on <u>10/13, 1959</u> , and that death occurred at <u>2:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Florence E. Grady</u>		ADDRESS (Street, city or town, state) <u>1300-19-SX. N.W. DC 6</u> DATE SIGNED <u>10/14/59</u>	
PHYSICIAN'S NAME (Type) <u>FLORENCE E. GRADY</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-19-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>OCT 16 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>

MEDICAL CERTIFICATION

2

074

1

1 11602 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Item 1 Film G251 11-2-59 et CERTIFICATE OF DEATH 11558 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 SILVER SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>912 Heron Court (Private home)</u>		d. STREET ADDRESS <u>912 HERON COURT</u>	
3. NAME OF DECEASED (Type or print) <u>Benjamin George Hardy</u>		4. DATE OF DEATH <u>Oct. 23, 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 29, 1889</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BARBER</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>
13. FATHER'S NAME <u>PARROTT D. HARDY</u>		14. MOTHER'S MAIDEN NAME <u>SALOME Gaskill</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>Cosette J. Hardy</u>		Address <u>912 Heron Court</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myocardial Infarction</u> DUE TO (c) <u>Cardio-Vascular-Renal Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>3 years</u> <u>See notes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept. 17, 1959</u> , to <u>Oct. 23, 1959</u> , that I last saw the deceased alive on <u>Oct 23, 1959</u> , and that death occurred at <u>2:10 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lynwood Heiges</u>		ADDRESS (Street, city or town, state) <u>LYNWOOD HEIGES, M.D., F.A.C.A.</u>	
PHYSICIAN'S NAME (Type) <u>Lynwood Heiges</u>		DATE SIGNED <u>10/23/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-26-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN</u>		22d. LOCATION (City, town, or county) (State) <u>BLADENSBURG MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Deal Funeral Home</u>		ADDRESS <u>4812 G. Ave NW</u>	
24a. REC'D BY REGISTRAR <u>OCT 27 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11603

CERTIFICATE OF DEATH

Reg. Dist. No.

11559

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 5 hrs. d. NAME OF HOSPITAL (If not in hospital, give street address) Suburban Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville 26 d. STREET ADDRESS Day Road 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) NELLY ELIZABETH HASLAM		4. DATE OF DEATH Oct. 18, 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 16, 1879
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Somerfield, New Jersey		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Cromwell Haslam		14. MOTHER'S MAIDEN NAME Elizabeth Worsley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 103-09-5351	
17. INFORMANT Lloyd P. Haslam-Item# 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Strangled Umbilical Hernia with 48 hrs 560.2 DUE TO 1 foot of gangrenous ileum Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 18, 1959 , to Oct. 18, 1959 , that I last saw the deceased alive on Oct. 18, 1959 , and that death occurred at 10:45 M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Rockville, Md. 10/19/59			
ACTUAL SIGNATURE Arthur F. Woodward M.D.		PHYSICIAN'S NAME (Type) Arthur F. Woodward Rockville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/21/59	
22c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler-1331 E. Montg. Ave. Rockville, Md.		24a. REC'D BY REGISTRAR OCT 21 '59	
24b. REGISTRAR'S SIGNATURE Arthur F. Woodward			

11536

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville				c. LENGTH OF STAY IN 1b 26			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1715 Henry Road				d. STREET ADDRESS 1715 Henry Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Hedderson Last Hedderson				4. DATE OF DEATH Month October Day 25 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 26, 1880	
9. AGE (In years lost birthday) 79 yrs.		IF UNDER 1 YEAR Months 79 Days 79 Hours 79 Min.		IF UNDER 24 HRS. Months 79 Days 79 Hours 79 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired fitter, Hecht Co.				10b. KIND OF BUSINESS OR INDUSTRY New London, Conn.		11. BIRTHPLACE (State or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Charles H. Mayer				14. MOTHER'S MAIDEN NAME Genevieve Herman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 578-10-3728			
17. INFORMANT Elizabeth W. Hedderson				Address Rockville, Md. 1715 Henry Road.			
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-Vascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH 4 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 1, 1959 to Oct. 25, 1959 that I last saw the deceased alive on Oct. 25, 1959 and that death occurred at 10 AM , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) DATE SIGNED 10/25/59			
ACTUAL SIGNATURE J. Chester Brady M.D. 3574				PHYSICIAN'S NAME (Type) J. Chester Brady			
22a. BURIAL OR CREMATION: REMOVAL (Specify) Removal				22b. DATE THEREOF 10/28/59			
22c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery				22d. LOCATION (City, town, or county) (State) New Haven, Conn.			
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W.				24a. REC'D BY REGISTRAR OCT 27 '59			
24b. REGISTRAR'S SIGNATURE Arthur S. Hines							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Figure 10-11

1138

22

11604

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY 83X-3		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY IN 1b 29 days		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.			d. STREET ADDRESS 302 East Broad Street		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Edward Pritz HERMAN			4. DATE OF DEATH Month Day Year October 7 19 59		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-6-98		9. AGE (In years lost birthday) 61 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreign Service Off. U.S. Government		10b. KIND OF BUSINESS OR INDUSTRY Tennessee	11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME William HERMAN			14. MOTHER'S MAIDEN NAME Belle PRITZ		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WWI & II		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) (Wife) Annette C. HERMAN		Address Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral, head of pressure - metastasis 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO					INTERVAL BETWEEN ONSET AND DEATH 6 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Arteriosclerotic cardiac vascular disease					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State)	
21. I certify that I attended the deceased from 8 September 59 to 7 October, 1959 , that I last saw the deceased alive on 7 October 19 59 , and that death occurred at 6:00 A.M. , from the causes and on the date stated above.					
ACTUAL SIGNATURE [Signature]		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md.			
PHYSICIAN'S NAME (Type) D.P. OSBORNE CAPT MC USN		DATE SIGNED 10-7-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation 10-8-59		22b. DATE THEREOF 10-8-59		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	
22d. LOCATION (City, town, or county) Suitland Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawlers & Son		ADDRESS 1756 Penn Ave. N.W.		24a. REC'D BY REGISTRAR Washington D.C.	
24b. REGISTRAR'S SIGNATURE [Signature]					

Virginia

Montgomery

Settlement (Rural) 29 days

U.S. Naval Hospital, Bethesda, Md. 200 Road Road 2000

Edward Pratt - HEWMAN

Male White

Foreign Service Off. U.S. Government, Tennessee

William HEWMAN

Yes WVI 2 II (Wife) Anne C. HEWMAN same as 23

[Handwritten signature]

[Handwritten signature]

September 29 - 7 October 29

U.S. Naval Hospital, Bethesda Md.

U.S. Naval Hospital, Bethesda Md.

October 10-2-52 Cedar Hill Cemetery, Silverland Md.

Joseph G. Galt & Son 1750 Penn Ave. N.W. Washington D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 22b, Film G-251 11/2/59.c

11562

11605

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 4 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3 d. STREET ADDRESS 3130 Wisconsin Ave. N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Florence Ruth HOBBS			4. DATE OF DEATH Month Day Year October 26 19 59		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-31-72	9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.					
13. FATHER'S NAME William GORE			14. MOTHER'S MAIDEN NAME Ruth STOCKSTALD		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. (Daughter) Mabel H ANDERSON Same as #2		INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Congestive Heart Failure DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) Diabetes Mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH 6 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Pikesville, Maryland		(County) (State)			
21. I certify that I attended the deceased from 22 October 19 59 to 26 October 19 59 that I last saw the deceased alive on 26 October 19 59 and that death occurred at 3:35 PM , from the causes and on the date stated above.					
ACTUAL SIGNATURE R. G. Muth		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md. DATE SIGNED 10-27-59			
PHYSICIAN'S NAME (Type) R.G. MUTH LT MC USN		U.S. Naval Hospital, Bethesda Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-28-59		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge	
22d. LOCATION (City, town, or county) Pikesville, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE H. Sander and Sons North Ave. and Broadway Baltimore Md. <i>per H. Sander.</i>		ADDRESS Baltimore Md.		24a. REC'D BY REGISTRAR 30 59	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>					

11603

Director of Columbia

Washington

U.S. Naval Hospital, Bethesda Md. 3150 Wisconsin Ave. N.W.

Reference: Rush 10588 October 28

Female White 1-31-12 31

None Maryland U.S.

William Gore Irish Stockyard

No. (Mauder/Mabel H. Anderson Case 22)

26 October 26 October 26 October 26 October

U.S. Naval Hospital, Bethesda Md. 3150 Wisconsin Ave. N.W.

1-31-12 1-31-12 1-31-12 1-31-12

M. Gordon and Sons North Ave. and Broadway, Baltimore Md.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>12 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sen v Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Lyndon</u> Last <u>Hobbs</u>				4. DATE OF DEATH Month <u>10</u> Day <u>31</u> Year <u>1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/30/1901</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Postal Supt.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Post Office</u>	
11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>William E Hobbs.</u>		14. MOTHER'S MAIDEN NAME <u>Selena Lynn</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT Address <u>Robert S. Purcell - 2014 Ravenswood St. Hyattsville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pneumonia</u> DUE TO <u>587.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Post acute Coronary Occlusion</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>March</u> , 1952, to <u>Oct 31</u> , 1959, that I last saw the deceased alive on <u>Oct 31</u> , 1959, and that death occurred at <u>1:31 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6826 Riggs Rd Hyattsville, Md</u> DATE SIGNED <u>10/31/59</u> ACTUAL SIGNATURE <u>Wayne Glickfield</u> M.D. PHYSICIAN'S NAME (Type) <u>H. Wayne Glickfield</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/3/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Keedysville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Keedysville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co. - 2901 14th St., N.W. Washington 9, D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1-211

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male	
3. AGE 35		4. DATE OF BIRTH 1-21-38	
5. PLACE OF BIRTH Memphis, Tenn.		6. OCCUPATION None	
7. MARITAL STATUS Single		8. COLOR White	
9. EDUCATION High School		10. RELIGION None	
11. PRESENT ADDRESS Room 107, 215 North Howard St., Baltimore, Md.		12. DATE OF DEATH 4-4-68	
13. PLACE OF DEATH Room 107, 215 North Howard St., Baltimore, Md.		14. CAUSE OF DEATH Suicide by gunshot	
15. MANNER OF DEATH Suicide		16. SIGNATURE OF DECEASED (None)	
17. SIGNATURE OF WITNESSES (None)		18. SIGNATURE OF PHYSICIAN (None)	
19. SIGNATURE OF CORONER (None)		20. SIGNATURE OF JURY (None)	
21. SIGNATURE OF REGISTRAR (None)		22. SIGNATURE OF CLERK (None)	
23. SIGNATURE OF DEPUTY CLERK (None)		24. SIGNATURE OF ASSISTANT CLERK (None)	
25. SIGNATURE OF CHIEF CLERK (None)		26. SIGNATURE OF SUPERVISOR (None)	
27. SIGNATURE OF ASSISTANT SUPERVISOR (None)		28. SIGNATURE OF CLERK IN CHARGE (None)	
29. SIGNATURE OF CLERK IN CHARGE (None)		30. SIGNATURE OF CLERK IN CHARGE (None)	
31. SIGNATURE OF CLERK IN CHARGE (None)		32. SIGNATURE OF CLERK IN CHARGE (None)	
33. SIGNATURE OF CLERK IN CHARGE (None)		34. SIGNATURE OF CLERK IN CHARGE (None)	
35. SIGNATURE OF CLERK IN CHARGE (None)		36. SIGNATURE OF CLERK IN CHARGE (None)	
37. SIGNATURE OF CLERK IN CHARGE (None)		38. SIGNATURE OF CLERK IN CHARGE (None)	
39. SIGNATURE OF CLERK IN CHARGE (None)		40. SIGNATURE OF CLERK IN CHARGE (None)	
41. SIGNATURE OF CLERK IN CHARGE (None)		42. SIGNATURE OF CLERK IN CHARGE (None)	
43. SIGNATURE OF CLERK IN CHARGE (None)		44. SIGNATURE OF CLERK IN CHARGE (None)	
45. SIGNATURE OF CLERK IN CHARGE (None)		46. SIGNATURE OF CLERK IN CHARGE (None)	
47. SIGNATURE OF CLERK IN CHARGE (None)		48. SIGNATURE OF CLERK IN CHARGE (None)	
49. SIGNATURE OF CLERK IN CHARGE (None)		50. SIGNATURE OF CLERK IN CHARGE (None)	
51. SIGNATURE OF CLERK IN CHARGE (None)		52. SIGNATURE OF CLERK IN CHARGE (None)	
53. SIGNATURE OF CLERK IN CHARGE (None)		54. SIGNATURE OF CLERK IN CHARGE (None)	
55. SIGNATURE OF CLERK IN CHARGE (None)		56. SIGNATURE OF CLERK IN CHARGE (None)	
57. SIGNATURE OF CLERK IN CHARGE (None)		58. SIGNATURE OF CLERK IN CHARGE (None)	
59. SIGNATURE OF CLERK IN CHARGE (None)		60. SIGNATURE OF CLERK IN CHARGE (None)	
61. SIGNATURE OF CLERK IN CHARGE (None)		62. SIGNATURE OF CLERK IN CHARGE (None)	
63. SIGNATURE OF CLERK IN CHARGE (None)		64. SIGNATURE OF CLERK IN CHARGE (None)	
65. SIGNATURE OF CLERK IN CHARGE (None)		66. SIGNATURE OF CLERK IN CHARGE (None)	
67. SIGNATURE OF CLERK IN CHARGE (None)		68. SIGNATURE OF CLERK IN CHARGE (None)	
69. SIGNATURE OF CLERK IN CHARGE (None)		70. SIGNATURE OF CLERK IN CHARGE (None)	
71. SIGNATURE OF CLERK IN CHARGE (None)		72. SIGNATURE OF CLERK IN CHARGE (None)	
73. SIGNATURE OF CLERK IN CHARGE (None)		74. SIGNATURE OF CLERK IN CHARGE (None)	
75. SIGNATURE OF CLERK IN CHARGE (None)		76. SIGNATURE OF CLERK IN CHARGE (None)	
77. SIGNATURE OF CLERK IN CHARGE (None)		78. SIGNATURE OF CLERK IN CHARGE (None)	
79. SIGNATURE OF CLERK IN CHARGE (None)		80. SIGNATURE OF CLERK IN CHARGE (None)	
81. SIGNATURE OF CLERK IN CHARGE (None)		82. SIGNATURE OF CLERK IN CHARGE (None)	
83. SIGNATURE OF CLERK IN CHARGE (None)		84. SIGNATURE OF CLERK IN CHARGE (None)	
85. SIGNATURE OF CLERK IN CHARGE (None)		86. SIGNATURE OF CLERK IN CHARGE (None)	
87. SIGNATURE OF CLERK IN CHARGE (None)		88. SIGNATURE OF CLERK IN CHARGE (None)	
89. SIGNATURE OF CLERK IN CHARGE (None)		90. SIGNATURE OF CLERK IN CHARGE (None)	
91. SIGNATURE OF CLERK IN CHARGE (None)		92. SIGNATURE OF CLERK IN CHARGE (None)	
93. SIGNATURE OF CLERK IN CHARGE (None)		94. SIGNATURE OF CLERK IN CHARGE (None)	
95. SIGNATURE OF CLERK IN CHARGE (None)		96. SIGNATURE OF CLERK IN CHARGE (None)	
97. SIGNATURE OF CLERK IN CHARGE (None)		98. SIGNATURE OF CLERK IN CHARGE (None)	
99. SIGNATURE OF CLERK IN CHARGE (None)		100. SIGNATURE OF CLERK IN CHARGE (None)	

RECEIVED
MAY 10 1968
BALTIMORE, MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11606

CERTIFICATE OF DEATH

Reg. Dist. No.

11564

1. PLACE OF DEATH a. COUNTY XXX Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 735 Sligo Avenue		d. STREET ADDRESS 735 Sligo Avenue Apt. 208	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Madge McCallum Hollingsworth		4. DATE OF DEATH Month Day Year OCTOBER 25 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/6/1874
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Malcolm McCullum		14. MOTHER'S MAIDEN NAME Madora Geneva Wells	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Helen Hollingsworth		Address Silver Spring, 735 Sligo Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastrointestinal hemorrhage 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hepatic failure DUE TO (c) Biliary cirrhosis		INTERVAL BETWEEN ONSET AND DEATH 2 hrs 1 month 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic cholelithiasis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/21 , 19 59 , to 10/25 , 19 59 , that I last saw the deceased alive on 10/24 , 19 59 , and that death occurred at 11:50 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE James R. Coleman MD		ADDRESS (Street, city or town, state) 733 SLIGO AVE	
PHYSICIAN'S NAME (Type) James R. Coleman		DATE SIGNED 10/25/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 10/28/59	
22c. NAME OF CEMETERY OR CREMATORY North Bend Cemetery		22d. LOCATION (City, town, or county) (State) North Bend, Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Company		24a. REC'D BY REGISTRAR Washington, D.C.	
24b. REGISTRAR'S SIGNATURE Carlton S. Hines		DATE OCT 27 '59	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD. 18

CERTIFICATE OF DEATH

11-1887

11-1887

NAME OF DECEASED JAMES K. COLEMAN		SEX Male	
AGE 73		DATE OF BIRTH 10/24/1814	
PLACE OF BIRTH Baltimore, Md.		OCCUPATION Merchant	
RESIDENCE 733 Silver Spring Ave.		DATE OF DEATH 10/24/1904	
CAUSE OF DEATH Chronic Catarrh of the Prostate		PERIOD OF ILLNESS 10/24/1904	
PLACE OF DEATH Home		SIGNATURE OF DECEASED (None)	
SIGNATURE OF WITNESSES J. H. [illegible] J. H. [illegible]		SIGNATURE OF PHYSICIAN J. H. [illegible]	
SIGNATURE OF CLERGYMAN J. H. [illegible]		SIGNATURE OF CORONER J. H. [illegible]	

The S. H. Press Company, Baltimore, Md.

11607

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN lb 173 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Alexandria c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 83 x .3 d. STREET ADDRESS 910 Jefferson Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) John		First John		Middle (None)		Last Holly		4. DATE OF DEATH Month October 14, Day 1959	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 16, 1884		9. AGE (In years last birthday) 75 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Locomotive Engineer		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Geremiah Holly				14. MOTHER'S MAIDEN NAME Sarah Whitt					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 713-05-4754		INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Gastrointestinal Hemorrhage 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Myelogenous Leukemia DUE TO (c) 2-3 years								INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 24 , 19 59 , to October 14 , 19 59 , that I last saw the deceased alive on October 14 , 19 59 , and that death occurred at 1:40 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 10/15/59 ACTUAL SIGNATURE Jerry S. Trier M.D. The Clinical Center PHYSICIAN'S NAME (Type) Jerry S. Trier, M.D. National Institutes of Health Bethesda 14, Maryland									
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried Oct. 19-59				22b. DATE THEREOF Oct. 19-59		22c. NAME OF CEMETERY OR CREMATORY Washington Park		22d. LOCATION (City, town, or county) (State) INDIANAPOLIS INDIANA	
23. FUNERAL DIRECTOR'S SIGNATURE Nash & Glaw / Paula Glaw Nende, Va				ADDRESS Nende, Va		24a. REC'D BY REGISTRAR OCT 19 59		24b. REGISTRAR'S SIGNATURE Arthur S. Howard	

Acute infectious leukemia
 2-3 years
 2 weeks
 No
 723-07-1721 The Clinical Center, Bethesda, Md., Maryland
 The Medical Record
 Sarah Smith
 Generalist Holly
 Locomotive Engineer
 Hallwood
 Virginia
 U. S. A.
 x
 February 16, 1961
 75
 October 11, 1961
 29
 The Clinical Center, Bethesda, Md., Maryland
 173 days
 Alexandria
 Virginia

Jerry S. Trier, M.D.
 The Clinical Center
 National Institutes of Health
 Bethesda, Md., Maryland
 10/25/61
 29
 1:00P
 29
 29

CERTIFICATE OF DEATH

11566

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8661 11th Ave S. Spg.</u>		d. STREET ADDRESS <u>18661 11th Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>RIVA</u> Middle <u>G N A P</u> Last <u>HORING</u>		4. DATE OF DEATH Month <u>10</u> Day <u>2</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR: Months <u>2</u> Days <u>2</u> Hours <u>19</u> Min. <u>59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House doctor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Registration</u>	
13. FATHER'S NAME <u>Abraham</u>		14. MOTHER'S MARDEN NAME <u>Libby</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown. If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs Libby Davis Leinster</u>		Address <u>8661-11th Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>ARTERIO SCLEROTIC HEART DISEASE</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 Hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1955</u> to <u>Oct-2</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Oct. 2</u> , 19 <u>59</u> , and that death occurred at <u>1:30 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Max G. Sherer</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>2311 Colston Dr. 10/2-59</u>	
PHYSICIAN'S NAME (Type) <u>MAX G. SHERER, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/2-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Nat Capital Heb Cmn</u>	22d. LOCATION (City, town, or county) (State) <u>Wash DC</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home Wash DC</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 6 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur & Kline</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11609

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>VA.</u> b. COUNTY <u>WEST MORELAND</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GAITHERSBURG</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COLONIAL BEACH 83X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>REST HAVEN SANITORIUM</u>		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>V.</u> Last <u>HOY SR.</u>		4. DATE OF DEATH Month <u>10</u> Day <u>21</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-1-81</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PAINTER</u>	
11. BIRTHPLACE (State or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>PETER HOY</u>		14. MOTHER'S MAIDEN NAME <u>AMELIA TRAVERS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>225-16-1627</u>	
17. INFORMANT <u>MRS. MARY WATSON</u>		Address <u>BETHESDA, MD. 9917 OLD GEORGETOWN ROAD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIAL HYPERTENSION</u> DUE TO (c) <u>ARTERIOSCLEROSIS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>ONE WEEK</u> <u>20 YEARS</u> <u>20 YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS - UREMIA</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>September 18, 1958</u> , to <u>October 21, 1959</u> , that I last saw the deceased alive on <u>October 20, 1959</u> , and that death occurred at <u>4:10 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John Hosenberger</u>		ADDRESS (Street, city or town, state) <u>26 N. SUMMIT AVE. BALTIMORE, MD.</u>	
PHYSICIAN'S NAME (Type) <u>GAITHERSBURG, MD.</u>		DATE SIGNED <u>OCT. 21, 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>10-23-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>WILMINGTON CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis Hollins</u>		ADDRESS <u>3821-14th St. N.W.</u>	24. REC'D BY REGISTRAR DATE <u>23 '59</u>
		24b. REGISTRAR'S SIGNATURE <u>John S. Kenna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARIANO STATE DEPARTMENT OF HEALTH - BALTIMORE, IS

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11610

CERTIFICATE OF DEATH

11568

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN lb 126 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY Riverside c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 85X-3 d. STREET ADDRESS No street address e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Carl Middle Edward Last Hudnall		4. DATE OF DEATH Month October Day 26 Year 1959					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH October 9, 1929		9. AGE (In years lost birthday) yrs. 30		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Miner			
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Lawrence Hudnall			
14. MOTHER'S MAIDEN NAME Vada Walker		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 233-44-0799			
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 204.3 DUE TO Septicemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Necrotizing, ulcerative colitis DUE TO (c) Acute lymphocytic leukemia		INTERVAL BETWEEN ONSET AND DEATH 6 days unknown 1 year		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 22 , 19 59 , to October 26 , 19 59 , that I last saw the deceased alive on October 26 , 19 59 , and that death occurred at 11:45A , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 10-26-59							
ACTUAL SIGNATURE Lawrence A. Gaydos		M.D. The Clinical Center National Institutes of Health Bethesda 14, Maryland					
PHYSICIAN'S NAME (Type) Lawrence A. Gaydos, M.D.							
22a. DATE OF REMOVAL (Specify) Removal		22b. DATE THEREOF 10/27/59		22c. NAME OF CEMETERY OR CREMATORY Charleston, West, Va.			
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. Washington, DC		ADDRESS Washington, DC		24a. REC'D BY REGISTRAR DATE OCT 28 '59			
				24b. REGISTRAR'S SIGNATURE Arthur S. Fisher			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

The S. H. Hines Co. Washington, DC

Removal 10/27/59

James M. A. O'Neil, M.D.

National Institutes of Health
The Clinical Center
Bethesda, Md., Maryland

Charleston, West, Va.

October 26 59 11:52 AM
June 22 59 October 26 59

acute lymphocytic leukemia

histological, microscopic

leukemia

633-11-0789 The Clinical Center, Bethesda, Md., Maryland

Lawrence H. Smith

The Federal Record
Veda Walker

Coal Miner

Coal Mining

West Virginia U. S. A.

Male White

October 9, 1959 30

Cell

Leukemia

Leukemia

October 26

136 days

Leukemia

The Clinical Center, Bethesda, Md., Maryland

Montgomery

West Virginia

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11611 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11569

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN TB <u>5 hrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P. G.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seat Pleasant</u> d. STREET ADDRESS <u>6410 Greig Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <u>Roy Lee Hughes</u>		4. DATE OF DEATH Month <u>10</u> - Day <u>22</u> Year <u>1959</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 26 1904</u>		9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>				11. BIRTHPLACE (State or foreign country) <u>Georgia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>							
13. FATHER'S NAME <u>Julius Hughes</u>								14. MOTHER'S MAIDEN NAME <u>Murdock</u>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u> </u>				17. INFORMANT <u>Mary Lucille Hughes - Wife</u> Address <u> </u>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terrmination of Brain stem</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 hours</u> <u>901.6</u> DUE TO <u>Intra cranial hemorrhage</u> <u>5 hours</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Contusions and lacerations</u> <u>5 hours</u> (c) <u> </u>																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fractured skull</u>																			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fall from scaffold while working on construction job</u>															
20c. TIME OF INJURY Month, Day, Year Hour <u>12:15</u> p. m. <u>10-22 1959</u>				20d. INJURY OCCURRED While of work <input checked="" type="checkbox"/> Not while of work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>bedg.</u>				20f. (City or town) <u>Silver Spring Montg Md</u> (County) <u> </u> (State) <u> </u>							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																			
ACTUAL SIGNATURE <u>Frank J. Broschant</u>								CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>								ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>								DATE SIGNED <u>10-23-59</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>10-26-59</u>				22c. NAME OF CEMETERY OR CREMATORY <u>F-T Lincoln Cem</u>				22d. LOCATION (City, town, or county) <u>Bladensburg Md</u> (State) <u> </u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers</u>								24a. REC'D BY REGISTRAR <u>Riverside Md</u>								24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral home or Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED (Last, first, middle initial) <u>JOHN J. SMITH</u>		2. SEX <u>Male</u>	
3. AGE <u>45</u>		4. RACE <u>White</u>	
5. CITY OR TOWN OF RESIDENCE <u>Baltimore</u>		6. STREET ADDRESS <u>1234 Main St.</u>	
7. OCCUPATION <u>Teacher</u>		8. DATE OF DEATH <u>10/15/1968</u>	
9. TIME OF DEATH <u>10:15 AM</u>		10. PLACE OF DEATH <u>Home</u>	
11. CAUSE OF DEATH (List all causes, beginning with the immediate cause, and ending with the underlying cause) <u>Myocardial infarction (heart attack) due to atherosclerosis of the coronary arteries.</u>			
12. MANNER OF DEATH (Natural, Accidental, Suicide, Homicide, Undetermined) <u>Natural</u>			
13. SIGNATURE OF MEDICAL EXAMINER <u>[Signature]</u>			
14. DATE OF SIGNATURE <u>10/15/1968</u>			
15. SIGNATURE OF REGISTRAR <u>[Signature]</u>			
16. DATE OF SIGNATURE <u>10/15/1968</u>			

Original
10/15/1968

11612

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 49 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.				d. STREET ADDRESS 127 Varnum Street N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Norma Middle Mae Last HUNTER		4. DATE OF DEATH		Month October Day 30 Year 19 59	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-15-37		9. AGE (In years lost birthday) 22 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Sidney JOHNSON				14. MOTHER'S MAIDEN NAME Sara HACKETT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		INFORMANT (Husband) Eccleseastes Hunter		Address Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 416X Congestive Heart Failure DUE TO Rheumatic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 8 hr							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11 September 1959 to 30 October 1959 , that I last saw the deceased alive on 30 October 19 59 , and that death occurred at 8:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE E. S. Muth M.D. U.S. Naval Hospital, Bethesda Md. 10-31-59 PHYSICIAN'S NAME (Type) R.G. MUTH LT MCUSN U.S. Naval Hospital, Bethesda Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-3-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE W.E. Jarvis 1432 U Street Washington, D.C.				24a. REC'D BY REGISTRAR DATE NOV 3 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

11612

11612

Washington

40 days

Personnel (Hawaii)

121, Vermont Street N.W.

U.S. Naval Hospital, Bethesda, Md.

October 30

NUMBER

NO

Form

22

8-12-37

10-12-37

U.S.

Washington, D.C.

Name

in service

State in which

Stanley Johnson

(Hawaii) (Washington) (Hawaii) (Washington)

30 October 37

11 November 37

30 October 37

U.S. Naval Hospital, Bethesda, Md.

U.S. Naval Hospital, Bethesda, Md.

Washington, D.C.

Washington National

10-12-37

Form

U.S. Naval Hospital, Bethesda, Md.

11613 Maryland STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Item 14 Film G252 11-17-59 et
 CERTIFICATE OF DEATH

11571

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 8 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hialeah 48X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 348 W. 64th Terrace			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First EDWARD Middle FLOYD Last HUNTLEY				4. DATE OF DEATH Month October Day 31 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 12, 1936	
9. AGE (In years last birthday) 23 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal Worker				10b. KIND OF BUSINESS OR INDUSTRY Sheet Metal		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Lee William Huntley				14. MOTHER'S MAIDEN NAME Hazel DeHog/Tuttle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 267-46-5790			
INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute gastrointestinal hemorrhage 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute lymphocytic leukemia DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH hours 10 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 23, 1959 , to October 31, 1959 , that I last saw the deceased alive on October 31, 1959 , and that death occurred at 11:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland							
ACTUAL SIGNATURE Charles E. Mengel M.D.				DATE SIGNED 11-1-59			
PHYSICIAN'S NAME (Type) Charles E. Mengel, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) SHIP RR		22b. DATE THEREOF 11-2-59		22c. NAME OF CEMETERY OR CREMATORY H		22d. LOCATION (City, town, or county) (State) HIALEAH FLA	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers				ADDRESS 1400 Chapin St NW		24a. REC'D BY REGISTRAR DATE NOV 3 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kins			

MEDICAL CERTIFICATION

2

050

I

Florida

Atlanta

Memphis

Michigan

8 days

Michigan

The Original Center, Rochester, N. Y.

210 W. 4th Street

Michigan

1950

1950

Male

May 12, 1950

New York

Chert Hill

Spent 1949-1950

Hazel Boley

Lee William Boley

207-16-5790 The Clinical Center, Rochester, N. Y.

Women: The Hospital record

Ames (unintentional) poisoning

Ames (unintentional) poisoning

October 31, 1950

October 31, 1950

October 31, 1950

11-1-59

The Clinical Center

General Hospital of Health

Rochester, N. Y.

Charles E. Boley, M. D.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11512

CERTIFICATE OF DEATH

11572

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>DDA</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>999 Washington Sanitarium + Hospital</u>				d. STREET ADDRESS <u>411 Ellsworth Dr.</u>			
3. NAME OF DECEASED (Type or print) <u>Clifford Warren Hurley</u>				4. DATE OF DEATH Month <u>10</u> Day <u>7</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-24-92</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Aero. Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Navy Dept.</u>		11. BIRTHPLACE (State or foreign country) <u>N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Hurley</u>				14. MOTHER'S M maiden NAME <u>Lottie Chase</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs Mildred R Hurley</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MASSIVE Retroperitoneal HEMORRHAGE</u> <u>451X</u> DUE TO <u>Rupture Arteriosclerotic Aneurysm Abdominal AORTA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/12</u> , 19 <u>57</u> , to <u>10/7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10/7</u> , 19 <u>59</u> , and that death occurred at <u>1:40 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>113 Carroll St NW Wash 12 DC</u> DATE SIGNED <u>10/7/59</u>							
ACTUAL SIGNATURE <u>Dean H Harding</u> M.D.				PHYSICIAN'S NAME (Type) <u>DEAN H. HARDING</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>TRANS. & BURIAL</u>		<u>10/9/59</u>		<u>Woodlawn Cemetery</u>		<u>Elmira, New York</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A Ziska</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 9 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Colin E. Kinnard</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Dr. Broschart - County Coroner was contacted 12

CERTIFICATE OF DEATH

11512

PLACE OF DEATH		MARRIAGE	
1. NAME OF DECEASED		2. DATE OF DEATH	
3. SEX		4. AGE	
5. RACE		6. OCCUPATION	
7. CAUSE OF DEATH		8. PLACE OF BIRTH	
9. DATE OF DEATH		10. TIME OF DEATH	
11. SIGNATURE OF DECEASED		12. SIGNATURE OF WITNESSES	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF CLERK	
15. SIGNATURE OF JUDGE		16. SIGNATURE OF SHERIFF	
17. SIGNATURE OF CORONER		18. SIGNATURE OF JURY	
19. SIGNATURE OF DISTRICT ATTORNEY		20. SIGNATURE OF COUNTY CLERK	
21. SIGNATURE OF STATE CLERK		22. SIGNATURE OF SECRETARY	
23. SIGNATURE OF ASSISTANT SECRETARY		24. SIGNATURE OF CHIEF CLERK	
25. SIGNATURE OF DEPUTY CLERK		26. SIGNATURE OF RECORDS CLERK	
27. SIGNATURE OF INDEXING CLERK		28. SIGNATURE OF FILE CLERK	
29. SIGNATURE OF DISTRIBUTION CLERK		30. SIGNATURE OF ARCHIVING CLERK	
31. SIGNATURE OF PRESERVATION CLERK		32. SIGNATURE OF REPRODUCTION CLERK	
33. SIGNATURE OF RELEASE CLERK		34. SIGNATURE OF REFERENCE CLERK	
35. SIGNATURE OF RESEARCH CLERK		36. SIGNATURE OF ANALYSIS CLERK	
37. SIGNATURE OF INTERVIEW CLERK		38. SIGNATURE OF SURVEILLANCE CLERK	
39. SIGNATURE OF INVESTIGATION CLERK		40. SIGNATURE OF MONITORING CLERK	
41. SIGNATURE OF EVALUATION CLERK		42. SIGNATURE OF REPORTING CLERK	
43. SIGNATURE OF COMMUNICATION CLERK		44. SIGNATURE OF COORDINATION CLERK	
45. SIGNATURE OF MANAGEMENT CLERK		46. SIGNATURE OF ADMINISTRATION CLERK	
47. SIGNATURE OF FINANCE CLERK		48. SIGNATURE OF PERSONNEL CLERK	
49. SIGNATURE OF TRAINING CLERK		50. SIGNATURE OF QUALITY CLERK	
51. SIGNATURE OF COMPLIANCE CLERK		52. SIGNATURE OF LEGAL CLERK	
53. SIGNATURE OF POLICY CLERK		54. SIGNATURE OF STRATEGY CLERK	
55. SIGNATURE OF PROGRAM CLERK		56. SIGNATURE OF PROJECT CLERK	
57. SIGNATURE OF TASK CLERK		58. SIGNATURE OF ROLE CLERK	
59. SIGNATURE OF RESPONSIBILITY CLERK		60. SIGNATURE OF ACCOUNTABILITY CLERK	
61. SIGNATURE OF PERFORMANCE CLERK		62. SIGNATURE OF EFFECTIVENESS CLERK	
63. SIGNATURE OF EFFICIENCY CLERK		64. SIGNATURE OF PRODUCTIVITY CLERK	
65. SIGNATURE OF QUALITY CLERK		66. SIGNATURE OF QUANTITY CLERK	
67. SIGNATURE OF VALUE CLERK		68. SIGNATURE OF COST CLERK	
69. SIGNATURE OF BENCHMARK CLERK		70. SIGNATURE OF TARGET CLERK	
71. SIGNATURE OF MEASURE CLERK		72. SIGNATURE OF INDICATOR CLERK	
73. SIGNATURE OF METRIC CLERK		74. SIGNATURE OF DATA CLERK	
75. SIGNATURE OF INFORMATION CLERK		76. SIGNATURE OF KNOWLEDGE CLERK	
77. SIGNATURE OF WISDOM CLERK		78. SIGNATURE OF SKILL CLERK	
79. SIGNATURE OF ABILITY CLERK		80. SIGNATURE OF CAPABILITY CLERK	
81. SIGNATURE OF POTENTIAL CLERK		82. SIGNATURE OF POSSIBILITY CLERK	
83. SIGNATURE OF OPPORTUNITY CLERK		84. SIGNATURE OF PROSPECT CLERK	
85. SIGNATURE OF PROSPECT CLERK		86. SIGNATURE OF PROSPECT CLERK	
87. SIGNATURE OF PROSPECT CLERK		88. SIGNATURE OF PROSPECT CLERK	
89. SIGNATURE OF PROSPECT CLERK		90. SIGNATURE OF PROSPECT CLERK	
91. SIGNATURE OF PROSPECT CLERK		92. SIGNATURE OF PROSPECT CLERK	
93. SIGNATURE OF PROSPECT CLERK		94. SIGNATURE OF PROSPECT CLERK	
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97. SIGNATURE OF PROSPECT CLERK		98. SIGNATURE OF PROSPECT CLERK	
99. SIGNATURE OF PROSPECT CLERK		100. SIGNATURE OF PROSPECT CLERK	

RECEIVED
BALTIMORE
MAY 10 1912

RECEIVED
BALTIMORE
MAY 10 1912

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11614

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11573

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Virginia b. COUNTY Alexandria	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 7 hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5100 River Rd.		d. STREET ADDRESS 3521 Wilson Ave.	
3. NAME OF DECEASED (Type or print) Claude Charles Hustwayte		4. DATE OF DEATH Oct 16 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-8-92
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nightwatchman		10b. KIND OF BUSINESS OR INDUSTRY Wash. Petro. Prod.	
11. BIRTHPLACE (State or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Claude C. Hustwayte		14. MOTHER'S MAIDEN NAME Mae Reddish	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 578-07-4635	
17. INFORMANT Violet Hustwayte-wife-same as 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage and Lacerations 976x DUE TO Conditions, if any, which gave rise to immediate cause (b) XX Bullet Wound Thru Skull (c), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted bullet wound thru skull	
20c. TIME OF INJURY Month, Day, Year ? 10-16 19 59		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Office Bldg.		20f. (City or town) (County) (State) Bethesda, Montg., Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED October 16, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/19/59	
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Bladensburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR OCT 19 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11615

CERTIFICATE OF DEATH

Reg. Dist. No.

11574

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooksville</u>		c. LENGTH OF STAY IN 1b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>"Greystone" Rt 1.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles Morris Irelan</u>		4. DATE OF DEATH Month <u>10</u> Day <u>30</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 8, 1905</u>
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Genl. Council</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>M.N.C.P.P.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>Dist. of Cal.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles Morris Irelan</u>		14. MOTHER'S MAIDEN NAME <u>Francis White</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, none or unknown) <u>No.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>yes</u>	
17. INFORMANT <u>Julia M. Irelan</u>		Address <u>Brooksville, Md (wife)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.0</u> DUE TO <u>Arterio sclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>3 yrs</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>3 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 10/30</u> , 19 <u>59</u> , to <u>10/30</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10/30</u> , 19 <u>59</u> , and that death occurred at <u>7:15 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. H. L. Irelan</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>10/30/59</u>	
PHYSICIAN'S NAME (Type) <u>C. H. L. Irelan</u>		M.D. <u>Sandy Spring, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11/2/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR DATE <u>NOV 3 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

11111

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF BIRTH <i>10/15/1910</i>		5. PLACE OF BIRTH <i>St. Louis, Mo.</i>		6. RACE <i>White</i>		7. OCCUPATION <i>Teacher</i>		8. MARITAL STATUS <i>Married</i>		9. DATE OF DEATH <i>11/10/1955</i>		10. PLACE OF DEATH <i>Home</i>		11. CAUSE OF DEATH <i>Heart Disease</i>		12. MANNER OF DEATH <i>Natural</i>		13. SIGNATURE OF PHYSICIAN <i>J. A. Smith</i>		14. SIGNATURE OF REGISTRAR <i>M. J. Jones</i>		15. DATE OF REGISTRATION <i>11/15/1955</i>		16. COUNTY <i>Baltimore</i>		17. STATE <i>Md.</i>	
18. FULL NAME OF NEXT OF KIN <i>John Doe</i>		19. ADDRESS OF NEXT OF KIN <i>123 Main St.</i>		20. CITY OF NEXT OF KIN <i>Baltimore</i>		21. STATE OF NEXT OF KIN <i>Md.</i>		22. FULL NAME OF DECEASED'S MOTHER <i>John Doe</i>		23. ADDRESS OF DECEASED'S MOTHER <i>123 Main St.</i>		24. CITY OF DECEASED'S MOTHER <i>Baltimore</i>		25. STATE OF DECEASED'S MOTHER <i>Md.</i>		26. FULL NAME OF DECEASED'S FATHER <i>John Doe</i>		27. ADDRESS OF DECEASED'S FATHER <i>123 Main St.</i>		28. CITY OF DECEASED'S FATHER <i>Baltimore</i>		29. STATE OF DECEASED'S FATHER <i>Md.</i>		30. SIGNATURE OF DECEASED'S MOTHER <i>J. A. Smith</i>		31. SIGNATURE OF DECEASED'S FATHER <i>M. J. Jones</i>		32. DATE OF DEATH <i>11/10/1955</i>		33. COUNTY <i>Baltimore</i>		34. STATE <i>Md.</i>	

1

RECEIVED
BALTIMORE
NOV 15 1955
STATE DEPARTMENT OF HEALTH
BALTIMORE

11616

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN lb 249 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47X-3 d. STREET ADDRESS 2500 Wisconsin Avenue, N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Winifred Mary-Theresa Jacoutot				4. DATE OF DEATH Month Day Year October 11, 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 4, 1918	
9. AGE (In years lost birthday) 41 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Jacoutot				14. MOTHER'S MAIDEN NAME Winifred Frewen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 130-09-8993			
17. INFORMANT The Medical Record				Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary congestion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of the breast DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 170X 7 years						INTERVAL BETWEEN ONSET AND DEATH hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 4, 1959 , to October 11, 1959 , that I last saw the deceased alive on October 11, 1959 and that death occurred at 7:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 10/12/59							
ACTUAL SIGNATURE John L. Lewis, Jr.				M.D. The Clinical Center			
PHYSICIAN'S NAME (Type) John L. Lewis, Jr., M.D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit 10/13/59		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		22d. LOCATION (City, town, or county) (State) New York, New York	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE OCT 14 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

The Clinical Center, Bethesda, Md.

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Background

சென்னை, 15 சூன் (ஐ.வி.என்) -

initial

1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 26

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International Journal of Health Services

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David and Jo Morrison

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Journal of Management Inquiry 16(4)

The Clinical Center

John J. Yonke, M.D.

11617

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Kensington</u>			
c. LENGTH OF STAY IN 1b <u>30 yrs</u>				d. STREET ADDRESS <u>10734 Conn. Ave.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10734 Conn. Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Norman C. Kefauver</u>				4. DATE OF DEATH Month Day Year <u>Oct. 20 1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 1, 1877</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Printing</u>		11. BIRTHPLACE (State or foreign country) <u>Montgomery Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Harmon C. Kefauver</u>				14. MOTHER'S MAIDEN NAME <u>Sallie Routzahn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Brother</u> Address <u>10734 Conn. Ave. Kensington, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic Heart Disease</u> DUE TO (c) <u>?</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Sept. 28, 1959</u> , to <u>Oct. 20, 1959</u> , that I last saw the deceased alive on <u>Oct. 19, 1959</u> , and that death occurred at <u>11:15</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Marion Bankhead</u> M.D.				ADDRESS (Street, city or town, state) <u>9241 Col. Blvd Silver Spring, Md.</u>			
DATE SIGNED <u>10/20/59</u>							
PHYSICIAN'S NAME (Type) <u>J. Marion Bankhead</u>				<u>Silver Spring, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/23/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u>		22d. LOCATION (City, town, or county) <u>Rockville, Maryland</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>OCT 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>William E. K...</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11577

11618

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>4 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hosp.</u>				e. STREET ADDRESS <u>4710 Waverly Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>New</u> Last <u>Kelly</u>				4. DATE OF DEATH Month <u>October</u> Day <u>12</u> , Year <u>19 59</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/3/1919</u>	
9. AGE (In years last birthday) <u>40</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>9</u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>New Brunswick, N.J.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>William A. New</u>				14. MOTHER'S MAIDEN NAME <u>Margaret McMannis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Yes</u>		17. INFORMANT <u>Hosp Record</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Encephalomalacia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral contusions</u> DUE TO (c) <u>Fractured Skull</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>4 days</u> <u>4 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Thrombocytopenia</u>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Reported to have fallen down basement steps at home</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>10/7/59 19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>	
20f. (City or town) <u>Garret Pk.</u>				20g. (County) <u>Montg.</u>		20h. (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J Broschart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>10-14-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Rockville, Maryland</u>				(State) <u> </u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

10

11513

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>—</u> b. COUNTY <u>—</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakoma Park</u>				c. LENGTH OF STAY IN 1b <u>3 mos-7 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Jacob</u> Middle <u>William</u> Last <u>Kriegel</u>				4. DATE OF DEATH Month <u>10</u> Day <u>21</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-18-75</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Artist-Lithographer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>America</u>							
13. FATHER'S NAME <u>Samuel Kriegel</u>				14. MOTHER'S MAIDEN NAME <u>Rachel Ginsburg</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Hospital Records</u>				Address <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>Oct 20</u> , 19 <u>59</u> , to <u>Oct 21</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Oct 20</u> , 19 <u>59</u> , and that death occurred at <u>3:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Abraham W. Danish</u>		M.D. <u>927 PERSHING DR</u>		ADDRESS (Street, city or town, state) <u>SILVER SPRING, MD</u>		DATE SIGNED <u>10-21-59</u>	
PHYSICIAN'S NAME (Type) <u>ABRAHAM W. DANISH</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>Oct. 22, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Lebanon Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hyattsville, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Danzansky</u>		ADDRESS <u>3521-14 ST NW</u>		24a. REC'D BY REGISTRAR <u>OCT 23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11513

1

Received for burial
May 11 - 1911
J. J. [illegible]

11537

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville c. LENGTH OF STAY IN lb 27 hrs 8 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Waveley Sanitarium		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase d. STREET ADDRESS 14 West Irving St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle H Last Ladd		4. DATE OF DEATH Month 10 Day 15 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-14-1865 AGE (In years last birthday) 94 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) Mass.
13. FATHER'S NAME H. Hammond		14. MOTHER'S MAIDEN NAME Kimball	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Myocardial decompensation, acute 7 days. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, general, severe 5 yrs DUE TO (c) —		19. INTERVAL BETWEEN ONSET AND DEATH 7 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year Hour o. m. — p. m. —	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	20f. (City or town) Rockville Md. (County) — (State) —
21. I certify that I attended the deceased from 1955 to Oct 15, 1959 , that I last saw the deceased alive on Oct 7, 1959 , and that death occurred at 545a M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Stewart Clapp		ADDRESS (Street, city or town, state) 3921 Ingomar St. Wash 15 D.C.	
PHYSICIAN'S NAME (Type) Stewart Clapp		DATE SIGNED 10-15-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 10/17/59	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	22d. LOCATION (City, town, or county) (State) Suitland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		24a. REC'D BY REGISTRAR Bethesda, Maryland	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		DATE OCT 19 '59	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1933

W. H. H. H.

Mr.

W. H. H. H.

Chief Clerk

Chief Clerk

Chief Clerk

Chief Clerk

Chief Clerk

Chief Clerk

Chief Clerk

Chief Clerk

Chief Clerk

Chief Clerk

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Chief Clerk

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11580

11514

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lahona Park</u> c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Pr. George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier, Md. 1616-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Dan Haven Rest Home</u>		d. STREET ADDRESS <u>3325 Chauncey Pl.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary ELIZ WHITE Lischer</u> First Middle Last		4. DATE OF DEATH Month <u>Oct.</u> Day <u>30</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-31-1893</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>6</u>	IF UNDER 24 HRS Hours <u>6</u> Min. <u>00</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	11. BIRTHPLACE (State or foreign country) <u>Vermont</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>CHARLES MEARS</u>	
14. MOTHER'S MAIDEN NAME <u>MINNIE MOREY</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Admthy Panchik</u> Address <u>Same as 2A</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>adenocarcinoma posterior mediastinum</u> <u>164X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>chronic advanced generalized arthritis</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>chronic advanced generalized arthritis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>12:40A</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan. 15, 1959</u> to <u>Oct 30, 1959</u> , that I last saw the deceased alive on <u>10/29, 1959</u> and that death occurred at <u>12:40A</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Daniel B. Washington</u> M.D.		ADDRESS (Street, city or town, state) <u>6234 90 Ave NW Wash DC</u> DATE SIGNED <u>10/30/59</u>	
PHYSICIAN'S NAME (Type) <u>Daniel B. Washington M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11-2-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FT LINCOLN CEM</u>	22d. LOCATION (City, town, or county) (State) <u>BLADENSBURG MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers C</u> ADDRESS <u>1400 Chapin St NW Wash D.C.</u>		24a. REC'D BY REGISTRAR <u>NOV 3 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11581

11619

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY <i>Washington, DC</i> 47X-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington, DC</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban Hospital</i>		d. STREET ADDRESS <i>4600 Conn. Ave. NW</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>J Stanley Long</i>		4. DATE OF DEATH Month Day Year <i>Oct 1 19 59</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 20, 1888</i>
9. AGE (In years last birthday) yrs. <i>71</i>		10. IF UNDER 1 YEAR Months Days Hours Min. <i>71</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Insurance Co.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Long & Curry</i>	
11. BIRTHPLACE (State or foreign country) <i>Altoona, Penna</i>		12. CITIZEN OF WHAT COUNTRY? <i>Usa</i>	
13. FATHER'S NAME <i>John Long</i>		14. MOTHER'S MAIDEN NAME <i>Belle M. Bowles</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>577-03-7411</i>	
17. INFORMANT <i>Edna Galleher Long</i>		Address <i>4600-Conn Ave NW</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of prostate with wide-spread metastases</i> DUE TO (b) <i>177X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>2 1/2 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>8-16-</i> , 19 <i>59</i> , to <i>Oct 1</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>Sept 30</i> , 19 <i>59</i> , and that death occurred at <i>10:15</i> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Stephen W. Deiter</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>3921 Ingomar St, NW Wash, DC.</i>	
PHYSICIAN'S NAME (Type) <i>STEPHEN W. DEITER, MD</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>	22b. DATE THEREOF <i>10/3/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Rock Creek Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Washington, D.C.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Co.</i>		24a. REC'D BY REGISTRAR <i>DATE OCT 5 '59</i>	
24b. REGISTRAR'S SIGNATURE <i>Curtis & Hines</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11620

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ST. MARY'S</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>1 WEEK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BENEDICT</u> Middle <u>BASIL</u> Last <u>LOVE</u>		4. DATE OF DEATH Month <u>OCTOBER</u> Day <u>21</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 9, 1871</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>1</u> Hours <u>1</u> Min.	11. IF UNDER 24 HRS. Months <u>8</u> Days <u>1</u> Hours <u>1</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNDERTAKER-MERCHANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MA</u>	
11. BIRTHPLACE (State or foreign country) <u>MA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>PHILIP GREENWELL LOVE</u>		14. MOTHER'S MAIDEN NAME <u>JOSEPHINE BOND</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u>		16. SOCIAL SECURITY NO. <u>NO.</u>	
17. INFORMANT <u>MRS. ANNA MICKUM</u>		Address <u>9906 HURST ST. BETHESDA 14, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause lost. (b) <u>CORONARY ARTERIOSCLEROSIS (ANGINA PECTORIS)</u> DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS; CARCINOMA (SKIN - FACE)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 HOURS</u> <u>SEVERAL YEARS.</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>OCTOBER 14, 1959</u> , to <u>OCTOBER 21, 1959</u> , that I last saw the deceased alive on <u>OCTOBER 21, 1959</u> , and that death occurred at <u>12:45 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph D. Connor</u>		ADDRESS (Street, city or town, state) <u>9420 OLD GEORGETOWN RD. 21 OCT. 59</u>	
PHYSICIAN'S NAME (Type) <u>JOSEPH D. CONNOR, M.D.</u>		DATE <u>BETHESDA 14, MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/24/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph's</u>	22d. LOCATION (City, town, or county) (State) <u>Morganza, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Clarke Mattingley</u>		ADDRESS <u>Leonardtwn, Maryland</u>	
24a. REC'D BY REGISTRAR <u>OCT 26 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Howard</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cardbox papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11621
CERTIFICATE OF DEATH

11583

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>56 Silver Spring</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>MARY</i> Middle <i>M</i> Last <i>LUCKETT</i>		4. DATE OF DEATH Month <i>10</i> Day <i>30</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Caucasian</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12/20/1922</i>
9. AGE (In years last birthday) <i>66</i> yrs.		10. DATE OF BIRTH <i>12/20/1922</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Hostess</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	
11. BIRTHPLACE (State or foreign country) <i>Bastrop-Texas</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Jim Brown</i>		14. MOTHER'S MAIDEN NAME <i>Lena ?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>YES-</i>	
17. INFORMANT <i>Ralph Lockett</i> Address <i>Son 1325 Howard St. N.W.</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Infarct, recent, right parietal lobe, Brain</i> DUE TO (b) <i>1325 Howard St. N.W.</i> DUE TO (c) <i>15 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Branchopneumonia, bilateral</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>10/19, 1959</i> , to <i>10/30, 1959</i> , that I last saw the deceased alive on <i>10/30, 1959</i> , and that death occurred at <i>1:05 P. M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John B. Unn</i> M.D.		ADDRESS (Street, city or town, state) <i>8805 Conn. Ave</i> DATE SIGNED <i>10/31/59</i>	
PHYSICIAN'S NAME (Type) <i>John B. Unn</i>		Cherry Chase 15, Md.	
22a. BURIAL, CREMATION, or other disposition (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11/3/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Ash Memorial</i>		22d. LOCATION (City, town, or county) (State) <i>Sandy Spring, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert C. Anawalt</i> ADDRESS <i>Rockville, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>NOV 5 '59</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur P. Thomas</i>			

STATE OF NEW YORK

11651

CASE OF DEATH

IN SENATE

January 1, 1901

REPORT OF THE

COMMISSIONER OF

THE DEPARTMENT OF

THE STATE

OF HEALTH

AND

THE

DEPARTMENT OF

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TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11584

11515

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>John Bennett Lyon</u>		4. DATE OF DEATH Month Day Year <u>10 17 1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-20-80</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired D.C. fire Department</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Btn. Chief</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nouch Lyon</u>		14. MOTHER'S M maiden NAME <u>FRANCES TUCKER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT Address <u>wife + old Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Prostate with Metastatic Carcinoma to Lung</u> DUE TO (c) <u>Tobacco</u>		INTERVAL BETWEEN ONSET AND DEATH <u>April 1959</u> <u>1955</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 16, 1959</u> , to <u>October 17, 1959</u> , that I last saw the deceased alive on <u>October 17, 1959</u> , and that death occurred at <u>8:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stuart L. Nelson</u>		ADDRESS (Street, city or town, state) <u>7600 Carroll Avenue Takoma Park Md.</u> DATE SIGNED <u>10/17/59</u>	
PHYSICIAN'S NAME (Type) <u>STUART L NELSON M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Entombment</u>		22b. DATE THEREOF <u>10/20/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Mausoleum</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter E. Humphrey Inc.</u> ADDRESS <u>8434 Ba. ave. S.S. Md.</u>		24. REC'D BY REGISTRAR DATE <u>OCT 20 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>C. L. Kline</u>			

1101

CERTIFICATE OF DEATH

11515

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
No. 1101
Date of Death: 11-15-1915
Place of Death: 11515
Name of Deceased: 11515
Age: 11515
Sex: 11515
Color: 11515
Cause of Death: 11515
Disease: 11515
Occupation: 11515
Signature: 11515
Witness: 11515
Registrar: 11515
Date: 11515
Place: 11515

11622

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. LENGTH OF STAY IN 1b 4 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS Rt. #1 Box 105							
3. NAME OF DECEASED (Type or print) First ANNA		Middle SOUTHERLAND		Last MACLEAN		4. DATE OF DEATH Month OCTOBER Day 9 Year 19 59	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/10/72		9. AGE (In years lost birthday) 87 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) MICHIGAN		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM LOWE				14. MOTHER'S MAIDEN NAME MARY MASON Dunn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT HOSPITAL RECORDS		Address OLNEY, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-Vascular Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 4 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Non-united hip fracture							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 55 to Oct 9 , 19 59 , that I last saw the deceased alive on Oct 8 , 19 59 , and that death occurred at 10:22A , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 10/9/59							
ACTUAL SIGNATURE Richard A. Yates				M.D.			
PHYSICIAN'S NAME (Type) RICHARD A. YATES, M. D.				OLNEY, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/12/59		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE OCT 13 '59	
				24b. REGISTRAR'S SIGNATURE Arthur E. Thoms			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

PROPERTY
GUY
2 DAYS
BENWOOD
MT. ST. JOE
SOUTHERLAND MAGNAN
OCTOBER 2 1899
WHITE
HOOVER
WILLIAM LONE
HOSPITAL RECORDS
GENEY, MARYLAND

10/13/99
RICHARD A. TATTS, JR.
10/13/99
GENEY, MARYLAND
RICHARD A. TATTS, JR.
10/13/99
GENEY, MARYLAND

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11586

11623

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 7 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY Parkersburg e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Claire Keturah MANDIGO			4. DATE OF DEATH Month Day Year October 19 1959				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-3-92	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) West Virginia			
12. CITIZEN OF WHAT COUNTRY? U.S.			13. FATHER'S NAME James BURTON				
14. MOTHER'S MAIDEN NAME Fannie LOCKHART			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				
16. SOCIAL SECURITY NO. (Husband) Brayton W. MANDIGO Same as #2			17. INFORMANT Address (Husband) Brayton W. MANDIGO Same as #2				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation due to Food 350X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PARALYSIS agitans DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2					INTERVAL BETWEEN ONSET AND DEATH 2 min.		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that I attended the deceased from 12 October 1959 to 19 October 1959 , that I last saw the deceased alive on 19 October 1959 , and that death occurred at 8:00 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda Md.							
ACTUAL SIGNATURE R. G. Muth		M.D. U.S. Naval Hospital, Bethesda Md.					
PHYSICIAN'S NAME (Type) R. G. MUTH LT MC USN		U.S. Naval Hospital, Bethesda Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-21-59	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Arlington Virginia				
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey		24a. REC'D BY REGISTRAR 7557 Wisconsin Ave. Bethesda Md.	24b. REGISTRAR'S SIGNATURE Oct 23 '59				

051

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11523

West Virginia

Bartholomew

U.S. Naval Hospital, Bethesda Md. 1008 First Avenue

Kathleen MANDIGO

1-3-52

West Virginia

James JACKSON

(Husband) Raydon K. MANDIGO Case no 12

12 October 52 12 October 52

U.S. Naval Hospital, Bethesda Md.

U.S. Naval Hospital, Bethesda Md.

Washington National Arlington Virginia

11523 11523

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11624

CERTIFICATE OF DEATH

11587

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Washington, D. C. b. COUNTY 47X-3			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Hall Nursing Home				d. STREET ADDRESS 5614 - 32nd St. N. W.			
3. NAME OF DECEASED (Type or print) Harriett M. MANN				4. DATE OF DEATH 10 29 1959			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 23, 1876	
9. AGE (In years last birthday) 83		10. IF UNDER 1 YEAR 10 Months 29 Days 19 Hours 59 Min.		11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of waking life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Housewife			
13. FATHER'S NAME Jesse McLendon				14. MOTHER'S MAIDEN NAME Marie Mitchener			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Frank J. Mann-5534		Address Wash. D.C. -30th St. N. W.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 296X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thrombocytopenic Purpura (c) Idiopathic Aplastic Anemia						INTERVAL BETWEEN ONSET AND DEATH 3 days 1 year 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19				20d. INJURY OCCURRED While Nat while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from APRIL 15, 1959 , to 10-29, 1959 , that I last saw the deceased alive on 10-29, 1959 , and that death occurred at 11:10 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Peyton R. Evans				ADDRESS (Street, city or town, state) Washington Clinic, Wash D.C.			
DATE SIGNED 10-29-59				DATE SIGNED 10-29-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/31/59		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Prince Georges Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Company				ADDRESS Washington, D.C.		24a. REC'D BY REGISTRAR DATE OCT 30 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Evans							

CERTIFICATE OF DEATH

1. NAME OF DECEASED John Doe		2. SEX Male		3. AGE 45	
4. DATE OF DEATH Jan 15, 1920		5. TIME OF DEATH 10:30 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Heart Disease		8. DISEASE OR INJURY Myocardial Infarction		9. PREVIOUS ILLNESS Hypertension	
10. SIGNATURE OF PHYSICIAN Dr. J. Smith		11. SIGNATURE OF WITNESSES John Doe, Jr.		12. SIGNATURE OF DECEASED John Doe	
13. SIGNATURE OF REGISTRAR John Doe		14. SIGNATURE OF CLERK John Doe		15. SIGNATURE OF NOTARY John Doe	

MASS LAND STATE DEPARTMENT OF HEALTH - BOSTON, 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 11628 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11588

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b 5 yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2005 Shorefield Rd.			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring d. STREET ADDRESS 2005 Shorefield Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Sylvia First MATRIKIAN Middle Matoian Last 4. DATE OF DEATH Oct. 25, 1959 Month Oct. Day 25 Year 19			5. SEX female 6. COLOR OR RACE white 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 8/15/1894 9. AGE (in years last birthday) 65 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home maker 11. BIRTHPLACE (State or foreign country) Armenia 12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Unknown Astor Balian 14. MOTHER'S MAIDEN NAME Unknown Mary Neshanian 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Troy Peters (son in law) Address Item 2			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Hypertention Conditions, if any, which gave rise to immediate cause (b) 420.1 (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 Hour o. m. p. m. 20d. INJURY OCCURRED White <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		
ACTUAL SIGNATURE Frank J. Broschart M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED Oct. 25, 1959 EXAMINER'S NAME (Type) Frank J. Broschart ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 22b. DATE THEREOF 10/28/59 22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY 22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND		
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Pumphrey, Inc. ADDRESS SILVER SPRING, MD. 24a. REC'D BY REGISTRAR OCT 28 59 24b. REGISTRAR'S SIGNATURE William A. Thomas					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE UNIVERSITY OF CHICAGO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11626

CERTIFICATE OF DEATH

11589

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHEATON WOODS-</u>		c. LENGTH OF STAY IN 1b <u>WHEATON WOODS - WHEATON AREA.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANTONIO</u> Middle <u>MAZZARA</u> Last <u>MAZZARA</u>		4. DATE OF DEATH Month <u>10</u> Day <u>18</u> Year <u>19 59</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-13-1895</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) <u>64</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>ITALY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SALVATORE MAZZARA</u>		14. MOTHER'S MAIDEN NAME <u>CALEDONIA ACESTE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>053-09-3133</u>	
17. INFORMANT <u>CLARA GIACALONE</u>		Address <u>-4600 - GLASGOW DR.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic capillary</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Tuberculosis of lung -</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>Seven yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>October 10, 1959</u> to <u>October 10, 1959</u> , that I last saw the deceased alive on <u>October 10, 1959</u> , and that death occurred at <u>3:00 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dr. John N. Triens</u>		ADDRESS (Street, city or town, state) <u>William T. Marcus MD</u>	
PHYSICIAN'S NAME (Type) <u>John N. Triens MD</u>		DATE SIGNED <u>William T. Marcus MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-21-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>	22d. LOCATION (City, town, or county) (State) <u>Maryland.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Timothy Hannon</u>		24b. REGISTRAR'S SIGNATURE <u>Calvin S. Hana</u>	
ADDRESS <u>-3831 - GR. Ave</u>		24c. REC'D BY REGISTRAR <u>NOV 22 '59</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

CERTIFICATE OF DEATH

11 1934

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11627

CERTIFICATE OF DEATH

Reg. Dist. No.

11591

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Marie Middle B. Last McCathran		4. DATE OF DEATH Month 10 Day 22 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/18/78
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months 10 Days 22 Hours 19 Min. 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME (unknown) Sweeney		14. MOTHER'S MAIDEN NAME Julia Qui 11	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Daughter (Mrs. G ladding)		18. ADDRESS 7407 Meadow La. Chevy Chase, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia, terminal 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Nephrosclerosis, severe DUE TO (c) Hypertension, severe		INTERVAL BETWEEN ONSET AND DEATH One month 2 yrs + 5 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from _____, 1954, to Oct 22, 1959, that I last saw the deceased alive on Oct 21, 1959, and that death occurred at 10:05 M, from the causes and on the date stated above.		DATE SIGNED 10/22/59	
ACTUAL SIGNATURE Stewart Clapp		ADDRESS (Street, city or town, state) 3921 Ingomar St. N.W. Wash D.C.	
PHYSICIAN'S NAME (Type) Stewart Clapp		M.D. Wash D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/24/59	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Prince Georges Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Company		ADDRESS Washington, D.C.	
24a. REC'D BY REGISTRAR OCT 23 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

CERTIFICATE OF DEATH

11887

1. Name of deceased	2. Sex	3. Age	4. Date of death	5. Place of death	6. Cause of death	7. Signature of physician	8. Signature of registrar
John Doe	Male	45	10-23-32	Home	Heart Disease	[Signature]	[Signature]

1. Name of deceased: John Doe
2. Sex: Male
3. Age: 45
4. Date of death: 10-23-32
5. Place of death: Home
6. Cause of death: Heart Disease
7. Signature of physician: [Signature]
8. Signature of registrar: [Signature]

1. Name of deceased: John Doe
2. Sex: Male
3. Age: 45
4. Date of death: 10-23-32
5. Place of death: Home
6. Cause of death: Heart Disease
7. Signature of physician: [Signature]
8. Signature of registrar: [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11628

CERTIFICATE OF DEATH

Reg. Dist. No.

11592

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. LENGTH OF STAY IN 1b 8 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GAITHERSBURG			
				d. STREET ADDRESS RT. #3			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First ALPHA Middle JANE Last MC CONNELL				4. DATE OF DEATH Month OCTOBER Day 8 Year 19 59			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/21/02	
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife				10b. KIND OF BUSINESS OR INDUSTRY Home Work		11. BIRTHPLACE (State or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Alfred McConnell				14. MOTHER'S MAIDEN NAME Ida Gill -			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service				16. SOCIAL SECURITY NO.		17. INFORMANT HOSPITAL RECORDS, Address OLNEY, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Vascular Accident 10 days DUE TO (c) Hypertension							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 9/29/ , 19 59 , to 10/8/ , 19 59 , that I last saw the deceased alive on 10/8 , 19 59 , and that death occurred at 7:50 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE L. I. Leal M.D.							
PHYSICIAN'S NAME (Type) L. I. LEAL, M. D.				GAITHERSBURG, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-11-59		22c. NAME OF CEMETERY OR CREMATORY McConnell		22d. LOCATION (City, town, or county) (State) Jonesville Va	
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner, Gaithersburg, Md.				24a. REC'D BY REGISTRAR DATE OCT 13 '59		24b. REGISTRAR'S SIGNATURE Arthur A. Hanks	

CERTIFICATE OF DEATH

11837

NAME OF DECEASED ALBERT J. CONNELL		SEX MALE		AGE 37	
PLACE OF BIRTH VIRGINIA		DATE OF BIRTH OCTOBER 27, 1902		PLACE OF DEATH BALTIMORE, MARYLAND	
OCCUPATION LABORER		CAUSE OF DEATH CORONARY ARTERY DISEASE		MANNER OF DEATH NATURAL	
DATE OF DEATH OCTOBER 27, 1937		TIME OF DEATH 10:30 AM		PLACE OF INTERMENT GREENWICH CEMETERY	
NAME OF PHYSICIAN DR. J. H. CONNELL		NAME OF FUNERAL HOME J. H. CONNELL		NAME OF UNDERTAKER J. H. CONNELL	
NAME OF NEXT OF KIN ALBERT J. CONNELL		NAME OF WITNESS ALBERT J. CONNELL		NAME OF REGISTRAR ALBERT J. CONNELL	
NAME OF COUNTY BALTIMORE		NAME OF CITY BALTIMORE		NAME OF STATE MARYLAND	

11837

This certificate is to be filled out by the physician or other person who has attended the deceased, or by the coroner, or by the registrar, or by the undertaker, or by the funeral home, or by the next of kin, or by the person who has taken charge of the funeral, or by the person who has taken charge of the interment, or by the person who has taken charge of the burial, or by the person who has taken charge of the cremation, or by the person who has taken charge of the other disposition of the body.

Item 21 FilmG250 10-20-59 et

CERTIFICATE OF DEATH

Reg. Dist. No.

MEDICAL CERTIFICATION

VS A15 (4)
15M 10/57

CERTIFICATE OF DEATH

11622

Reg. No. 11622

Name of Deceased		Robert A. Robinson, Baltimore, Md.	
Date of Birth		October 10, 1900	
Place of Birth		Baltimore, Md.	
Sex		Male	
Race		White	
Marital Status		Single	
Occupation		Student	
Cause of Death		Pneumonia	
Date of Death		January 6, 1922	
Place of Death		Home, 1012 E. Baltimore St., Baltimore, Md.	
Physician		Dr. J. H. Smith	
Burial Place		Greenwood Cemetery, Baltimore, Md.	
Burial Date		January 10, 1922	
Signature of Physician		J. H. Smith	
Signature of Registrar		J. H. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11630

CERTIFICATE OF DEATH

Reg. Dist. No.

11594
115

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 26 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 1812 "K" Street N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last Robert Francis MC DERMOTT				4. DATE OF DEATH Month Day Year October 17 1959											
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-10-15		9. AGE (In years last birthday) 44 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer				10b. KIND OF BUSINESS OR INDUSTRY News Press				11. BIRTHPLACE (State or foreign country) Pennsylvania				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Leo MC DERMOTT						14. MOTHER'S MAIDEN NAME Mary Hora									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II				16. SOCIAL SECURITY NO. INFORMANT				Address (Wife) Claudia McDermott Same as #2							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										INTERVAL BETWEEN ONSET AND DEATH 10 min					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 21 Sept , 19 59 , to 17 October 19 59 that I lost saw the deceased alive on 17 October , 19 59 , and that death occurred at 8:48 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Bethesda Md. 10-17-59 ACTUAL SIGNATURE B.C. Johnson M.D. U.S. Naval Hospital, Bethesda Md. PHYSICIAN'S NAME (Type) B.C. JOHNSON ICDR MC USN U.S. Naval Hospital, Bethesda Md.															
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-21-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National				22d. LOCATION (City, town, or county) (State) Arlington Virginia							
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawlers ADDRESS 1756 Penn. Ave. Washington D.C.						24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Arthur S. K...							

1930

LETTERS OF CREDIT

Director of Consular

Department

Washington

20 days

Residence (Hotel)

U.S. Naval Hospital, Bethesda Md.

U.S. Naval Hospital, Bethesda Md.

NO DEPOSIT

Francis

Robert

October

5-10-30

White

Male

U.S.

Pennsylvania

Howe Press

Printer

Mary Rose

NO DEPOSIT

(Wife) Columbia Metropolitan Bank as 45

WM II

22 October 30

21 days

50

11 October

U.S. Naval Hospital, Bethesda Md.

U.S. Naval Hospital, Bethesda Md.

Arlington National - Arlington Virginia

Joseph Gorman 150 Penn. Ave. Washington, D.C.

11631

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7905 TAKOMA AVENUE				d. STREET ADDRESS 7905 TAKOMA AVENUE			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First LUCY Middle G. Last McDONNELL				4. DATE OF DEATH Month OCTOBER 18 Day 19 Year 59			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 28, 1881	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months 78 Days 78 Hours 78 Min.		IF UNDER 24 HRS. Months 78 Days 78 Hours 78 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) WASHINGTON, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JAMES B. EVANS				14. MOTHER'S MAIDEN NAME MARY ANN McGOWAN McCANNA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		INFORMANT JOHN E. SIMMONS, 7905 TAKOMA AVE., SILVER SPRING			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X starvation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of stomach DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 2 wks 1 yr.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 20, 1959 to Oct 18, 1959 , that I last saw the deceased alive on Oct 17, 1959 , and that death occurred at 9:10 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Donald Nelson				ADDRESS (Street, city or town, state) 10620 Georgia Ave., Silver Spring, Md.		DATE SIGNED 10/19/59	
PHYSICIAN'S NAME (Type) DONALD NELSON							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF OCT. 21, 1959		22c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D. C.	
23. FUNERAL DIRECTOR'S NAME AND ADDRESS WARNER E. PUMPHREY, INC. Raymond A. Ziska				24a. REC'D BY REGISTRAR OCT 20 1959		24b. REGISTRAR'S SIGNATURE Clifford S. Kraus	

REPORT OF THE
SURGEON GENERAL
ON THE
MORBIDITY AND MORTALITY
IN THE
NAVY AND MARINE CORPS
FOR THE
YEAR 1930

THE
NAVY AND MARINE CORPS
DEPARTMENT OF HEALTH
WASHINGTON, D. C.
1931

11632

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 57 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE South Carolina b. COUNTY Columbia c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 77x-3 d. STREET ADDRESS 4115 Bee Clift Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Patrick Lawrence MC NALLY			4. DATE OF DEATH Month Day Year October 5 19 59				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-21-04	9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months Days Hours 5 19 59		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) Georgia			
12. CITIZEN OF WHAT COUNTRY? U.S.			13. FATHER'S NAME Thomas MC NALLY				
14. MOTHER'S MAIDEN NAME Agnes ALLEN			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes 1937 to 40				
16. SOCIAL SECURITY NO. 577-26-5047			17. (Official hospital records)				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary obstruction (c) Coronary atherosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 10 years					INTERVAL BETWEEN ONSET AND DEATH minutes?		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that I attended the deceased from 9 August, 19 59 to 5 October, 19 59 that I last saw the deceased alive on 5 October, 19 59 , and that death occurred at 2:00PM from the causes and on the date stated above.							
ACTUAL SIGNATURE F.H. O'Connell		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md.		DATE SIGNED 10-5-59			
PHYSICIAN'S NAME (Type) F.H. O'CONNELL LCDR MC USN U.S. Naval Hospital, Bethesda Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-13-59	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Arlington Va.				
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Bump...		ADDRESS Wisconsin Bethesda Md.	24a. REC'D BY REGISTRAR OCT 13 '59	24b. REGISTRAR'S SIGNATURE Arthur S. K...			

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11633

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>—</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 47x-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>2853 Ontario Rd. N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Alta</u> Last <u>Merrow</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>17</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-25-92</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Penn., Bradford</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Ned Smith</u>				14. MOTHER'S MAIDEN NAME <u>Whedon, Alta</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT <u>James F. Merrow, 2853 Ontario Rd. N.W.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>5501 Congestive heart failure</u> DUE TO (b) <u>Peritonitis</u> DUE TO (c) <u>Acute suppurative appendicitis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 day</u> <u>approx 4 day</u> <u>approx 4 day</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 14</u> , 19 <u>59</u> , to <u>Oct 17</u> , 19 <u>59</u> that I last saw the deceased alive on <u>Oct 16</u> , 19 <u>59</u> , and that death occurred at <u>3:50</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>George Sharpe m.o. 10511 SUMMIT AVE KENSINGTON Md.</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>George SHARPE 10511 Summit Ave Kensington Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation Oct. 19 1959</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory Bladensburg Md</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. CHAMBERS</u>				ADDRESS <u>1400 Chapin St N.W. Wash DC</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 20 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kane</u>			

1

074

1

2

1

VS A15 (4)
15M 9/58

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11832

MADE IN U.S.A.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11598

11634

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 7 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2211 Seminary Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ALFRED STEVEN MERRELL		4. DATE OF DEATH Month OCT. Day 30 Year 19 59	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/11/82
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk (retired)		10b. KIND OF BUSINESS OR INDUSTRY Grocery Store	
11. BIRTHPLACE (State or foreign country) Connecticut		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME STEVEN MERRELL		14. MOTHER'S MAIDEN NAME LORETTA JANE MASON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) NO		16. SOCIAL SECURITY NO. 212-18-8235	
17. INFORMANT Mrs. Helen M. Murphy, 2211 Seminary Rd.		Address Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVIEW BETWEEN ONSET AND DEATH 2 hrs ?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/23 , 19 59 , to 10/30 , 19 59 , that I last saw the deceased alive on 10/28 , 19 59 , and that death occurred at 11 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE William D. Aud M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 9006 Lakeside Rd, 10/30/59	
PHYSICIAN'S NAME (Type) WILLIAM D. AUD		Silver Spring, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 11/2/59	22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY	22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD.
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Huska		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR NOV 3 59		24b. REGISTRAR'S SIGNATURE C. H. S. Pumphrey	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11024

1910

<p>1. Name of deceased: <u>JOHN J. HENRY</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>35</u></p>		<p>4. Date of birth: <u>Jan 15, 1875</u></p>	
<p>5. Place of birth: <u>St. Louis, Mo.</u></p>		<p>6. Date of death: <u>Dec 10, 1910</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Place of death: <u>Home</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>		<p>10. Signature of registrar: <u>[Signature]</u></p>	
<p>11. Date of registration: <u>Dec 15, 1910</u></p>		<p>12. Office of registration: <u>Baltimore, Md.</u></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11635
CERTIFICATE OF DEATH

11599

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington Montgomery		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Sanit. 3000 McComas Avenue		d. STREET ADDRESS 6010 Sonoma Road		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Carrie Middle D. Last Merrick		4. DATE OF DEATH Month October Day 5 Year 1959		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/17/1875	
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months 84 Days 0 Hours 0 Min. 0	11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William Dudley		14. MOTHER'S MAIDEN NAME Rachael Thomas		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. no		
INFORMANT Records at Kensington Gardens Sanit.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Arteriosclerotic Heart Disease DUE TO (b) Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) Senile Arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH 18 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile Arteriosclerosis				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from June 10-5- , 19 54 , to Oct 5 , 19 59 , that I last saw the deceased alive on 10-5- , 19 59 , and that death occurred at 11:25 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4201 Fessenden St N.W. 10-639 DATE SIGNED Oct 8 59				
ACTUAL SIGNATURE P. P. Andrews M.D.		PHYSICIAN'S NAME (Type) P. P. ANDREWS M.D. Washington D. C.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 10/6/59		
22c. NAME OF CEMETERY OR CREMATORY Sudlersville		22d. LOCATION (City, town, or county) (State) Sudlersville, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. ADDRESS Wash. D.C. 2901 14th St., N.W.		24a. RECEIVED BY REGISTRAR Oct 8 59 DATE		
24b. REGISTRAR'S SIGNATURE Arthur E. Hines				

very

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CERTIFICATE OF DEATH

11000

DATE OF DEATH

AGE

SEX

PLACE OF BIRTH

DATE

TIME

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

AGE

SEX

PLACE OF BIRTH

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DATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

DATE OF DEATH

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be certified with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11637
CERTIFICATE OF DEATH

Item 8 Film G249 10-13-59 et

11601

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. LENGTH OF STAY IN 1b 26	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		d. STREET ADDRESS 419 Park Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rest Haven Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle L Last Mills		4. DATE OF DEATH Month 10 Day 6 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 9/17/64
9. AGE (In years lost birthday) yrs. 94		IF UNDER 1 YEAR Months 10 Days 19 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Track Foreman		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME John Mills		14. MOTHER'S MAIDEN NAME Martha Day	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
INFORMANT Sadie Johnson-daughter-same as 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Cerebral Thrombosis DUE TO (b) Cerebral Arteriosclerosis DUE TO (c) Arteriosclerotic C.V. Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Operation 2 weeks ago for Enlarged Heart			
INTERVAL BETWEEN ONSET AND DEATH 24 hrs Indef. Indef.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/1, 1957 , to 10/6, 1959 , that I last saw the deceased alive on 10/6, 1959 , and that death occurred at 12:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rockville, Md. DATE SIGNED 10/6/59			
ACTUAL SIGNATURE Stephen N. Jones		M.D. Rockville, Md.	
PHYSICIAN'S NAME (Type) Stephen N. Jones, M.D.		Rockville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/8/59	
22c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR DET 7 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1883

THE STATE OF TEXAS

1883

1

County of ... State of Texas
I, the undersigned, Clerk of the County of ... State of Texas, do hereby certify that the within and foregoing is a true and correct copy of the ... as the same appears from the records of said County.

Witness my hand and the seal of said County, at the City of ... this ... day of ... 1883.

Clerk of the County of ... State of Texas

11638 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 3, 5, 6 & 7 Film G250 10/22/59 jwr

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7 Cedar Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Laveta</u> Middle <u>Mary</u> Last <u>Mills</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>17</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-2-1894</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>							
13. FATHER'S NAME <u>John T. Martin</u>				14. MOTHER'S MAIDEN NAME <u>Emma M. Spater</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Ralph Mills - Stum</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10-18-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>10-20-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rosehill Oak</u>		22d. LOCATION (City, town, or county) (State) <u>Gaithersburg md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest G. Farnham</u>				ADDRESS <u>Gaithersburg md</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 20 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knead</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF JURY		17. SIGNATURE OF JURY		18. SIGNATURE OF JURY	
19. SIGNATURE OF JURY		20. SIGNATURE OF JURY		21. SIGNATURE OF JURY	
22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY	
25. SIGNATURE OF JURY		26. SIGNATURE OF JURY		27. SIGNATURE OF JURY	
28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY	
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37. SIGNATURE OF JURY		38. SIGNATURE OF JURY		39. SIGNATURE OF JURY	
40. SIGNATURE OF JURY		41. SIGNATURE OF JURY		42. SIGNATURE OF JURY	
43. SIGNATURE OF JURY		44. SIGNATURE OF JURY		45. SIGNATURE OF JURY	
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49. SIGNATURE OF JURY		50. SIGNATURE OF JURY		51. SIGNATURE OF JURY	
52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY	
55. SIGNATURE OF JURY		56. SIGNATURE OF JURY		57. SIGNATURE OF JURY	
58. SIGNATURE OF JURY		59. SIGNATURE OF JURY		60. SIGNATURE OF JURY	
61. SIGNATURE OF JURY		62. SIGNATURE OF JURY		63. SIGNATURE OF JURY	
64. SIGNATURE OF JURY		65. SIGNATURE OF JURY		66. SIGNATURE OF JURY	
67. SIGNATURE OF JURY		68. SIGNATURE OF JURY		69. SIGNATURE OF JURY	
70. SIGNATURE OF JURY		71. SIGNATURE OF JURY		72. SIGNATURE OF JURY	
73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY	
76. SIGNATURE OF JURY		77. SIGNATURE OF JURY		78. SIGNATURE OF JURY	
79. SIGNATURE OF JURY		80. SIGNATURE OF JURY		81. SIGNATURE OF JURY	
82. SIGNATURE OF JURY		83. SIGNATURE OF JURY		84. SIGNATURE OF JURY	
85. SIGNATURE OF JURY		86. SIGNATURE OF JURY		87. SIGNATURE OF JURY	
88. SIGNATURE OF JURY		89. SIGNATURE OF JURY		90. SIGNATURE OF JURY	
91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY	
94. SIGNATURE OF JURY		95. SIGNATURE OF JURY		96. SIGNATURE OF JURY	
97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY	
100. SIGNATURE OF JURY		101. SIGNATURE OF JURY		102. SIGNATURE OF JURY	

CERTIFICATE OF DEATH

Reg. Dist. No.

11516

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. Hyattsville</u>	
c. LENGTH OF STAY IN TB <u>12 mns.</u>		d. STREET ADDRESS <u>1400 East West Hwy</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lawrence Edward Morgans</u>		4. DATE OF DEATH Month Day Year <u>October 7 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-18-20</u>
9. AGE (In years last birthday) <u>39</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Security Guard</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Penna</u>	
11. BIRTHPLACE (State or foreign country) <u>Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Vincent B. Morgans</u>		14. MOTHER'S MAIDEN NAME <u>Helen Kusky</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Mrs. Ruby H. Morgans - wife</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>acute</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 7</u> , 19 <u>59</u> , to <u>Oct 7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Oct 7</u> , 19 <u>59</u> , and that death occurred at <u>6:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ernest A. Sarao</u> M.D.		ADDRESS (Street, city or town, state) <u>1077 15th St. N.W.</u>	
PHYSICIAN'S NAME (Type) <u>Ernest A. Sarao</u>		DATE SIGNED <u>10/7/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Oct 10-1959</u>		22b. DATE THEREOF <u>Oct 10-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fl. Lincoln</u>		22d. LOCATION (City, town, or county) <u>Sheddenburg Road Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Welles</u> ADDRESS <u>254 Carroll St NW, DC</u>		24a. REC'D BY REGISTRAR DATE <u>8 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Evans</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11517

CERTIFICATE OF DEATH

11604

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park Md.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington San & Hosp.</i>		d. STREET ADDRESS <i>16409 Eastern Ave</i>	
3. NAME OF DECEASED (Type or print) First <i>Perminia</i> Middle <i>Claude</i> Last <i>Morris</i>		4. DATE OF DEATH Month <i>Oct.</i> Day <i>15</i> Year <i>1959</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>Cauc</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4/18/08</i>
9. AGE (In years last birthday) <i>51</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Shop Foreman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>	
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Charles B Morris</i>		14. MOTHER'S MAIDEN NAME <i>Maude Shifflett</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>214 01 0263</i>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Subarachnoid hemorrhage severe</i> <i>330X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Lobar pneumonia rt lower lobe</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>10-12</i> , 19 <i>58</i> , to <i>10-15</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>10-15</i> , 19 <i>59</i> , and that death occurred at <i>11:50 A.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Samuel M. Bagant</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>5600 N.H. Ave, WASH. DC. 10/15/59</i>	
PHYSICIAN'S NAME (Type) <i>SAMUEL M. BAGANT</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Oct. 19, 1959</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Prince George's County, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur Walton, 254 Canal St NW DC</i>		ADDRESS <i>254 Canal St NW DC</i>	
24a. REC'D BY REGISTRAR <i>Oct 19 59</i>		24b. REGISTRAR'S SIGNATURE <i>Charles S. Hume</i>	

18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11639

11695

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FAIRLAND</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FAIRLAND NURSING HOME</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LAURA</u> Middle <u>MAY</u> Last <u>MUNDY</u>		4. DATE OF DEATH Month <u>10</u> Day <u>16</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 26, 1888</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even, if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>W. VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Patrick Mundy</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Geo. Wm. Kerns</u>		Address <u>11,307 Amherst Ave., Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>160.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Adeno-carcinoma Right Maxillary Sinus</u> DUE TO (c) <u>Pmo's</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 19, 1959</u> to <u>160.2</u> , 1959, that I last saw the deceased alive on <u>7 Oct 1959</u> , and that death occurred at <u>10:50 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>11134 Georgia Ave Silver Spring Md 16059</u> DATE SIGNED <u>11/34</u>			
ACTUAL SIGNATURE <u>Merton L. White</u>		M.D. <u>11/34</u>	
PHYSICIAN'S NAME (Type) <u>MERTON L. WHITE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 19, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc., Silver Spring, Md.</u>		24a. REC'D BY REGISTRAR <u>Oct 20 1959</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles E. Hume</u>		DATE	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11608

11640

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 4 hrs. 10 min.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle A. Last Myer		4. DATE OF DEATH Month 10 Day 20 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/16/05
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR Months 10 Days 20 Hours 19 Min. 59	11. IF UNDER 24 HRS. Months 10 Days 20 Hours 19 Min. 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Government	
11. BIRTHPLACE (State or foreign country) Wyoming		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Edgar A Myer		14. MOTHER'S MAIDEN NAME Dora Russell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) No	
17. INFORMANT Edgar Myer, Grandfather		Address Father	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exsanguination 581.0 DUE TO Bleeding gastro-esophageal Varices Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) Cirrhosis of liver (c) Cirrhosis of liver			INTERVAL BETWEEN ONSET AND DEATH Days years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 17 , 19 59 , to Oct 20 , 19 59 , that I last saw the deceased alive on Oct 20 , 19 59 , and that death occurred at 2:15 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Michel M. Healy		ADDRESS (Street, city or town, state) Washington, D.C.	
PHYSICIAN'S NAME (Type) MICHEL M. HEALY		WASHINGTON CLINIC, WASH., D. C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-23-1959	
22c. NAME OF CEMETERY OR CREMATORY Arlington NATIONAL		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Hawley's Sons, Wash., D.C.		ADDRESS Washington, D.C.	
24a. REC'D BY REGISTRAR OCT 26 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hanks	

074

2

1

CERTIFICATE OF DEATH

11002

A. M. 10 min. Chest pain

3:30 found deceased

Blanchard

White

Female



11641

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>Montg.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Randolph Hill</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Randolph Hill</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Agnew's Hosp. Md.</i>		d. STREET ADDRESS <i>4614 Olden Rd.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>ANNA</i> Middle <i>K</i> Last <i>MYERS</i>		4. DATE OF DEATH Month <i>Oct</i> Day <i>14</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 22 1894</i>
9. AGE (In years last birthday) <i>65</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Gov. Employee</i>	
11. BIRTHPLACE (State or foreign country) <i>South Dakota</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>George Knudson</i>		14. MOTHER'S MAIDEN NAME <i>Diana ?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Verlet Haver</i>		Address <i>4614 Olden Rd.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral thrombosis</i> <i>332x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral and General arteriosclerosis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>3 wks.</i> <i>2 + yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetic Mellitus since 1945</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <i>19</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>3:45 PM</i> , 19 <i>Oct</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>13 Oct 1959</i> , and that death occurred at <i>4:40 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>A. H. Richwine</i> M.D.		ADDRESS (Street, city or town, state) <i>5522 Western Ave</i>	
DATE SIGNED <i>Cherry Chase 15 Md.</i>			
PHYSICIAN'S NAME (Type) <i>A. H. RICHWINE</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Oct 17, 1959</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Addison Chapel</i>	22d. LOCATION (City, town, or county) (State) <i>Seat Pleasant Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Deal Funeral Home</i>		ADDRESS <i>4812 He Ave NW</i>	
24a. REC'D BY REGISTRAR DATE <i>OCT 19 59</i>		24b. REGISTRAR'S SIGNATURE <i>William S. Hanna</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2/1/90
 Central and Eastern
 (Central)

Booklet written in 1942

At Richmond
Sept 1860

Grand Aveue 12/11/60

2-25 constant

1900-1910 West 2d Street 17

11642

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 6 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Francis Middle Martin Last Myers				4. DATE OF DEATH Month October Day 18 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 13, 1925	
9. AGE (In years last birthday) 34 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic				10b. KIND OF BUSINESS OR INDUSTRY Light & Power Co.		11. BIRTHPLACE (State or foreign country) Pennsylvania	
13. FATHER'S NAME Ira Myers				14. MOTHER'S MAIDEN NAME Mary Barr			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) yes WW II				16. SOCIAL SECURITY NO. Unascertainable			
17. INFORMANT The Medical Record				Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhagic bronchopneumonia DUE TO 204.1 Acute myelogenous leukemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 week 7 months							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 12, 19 59 to October 18, 19 59 , that I last saw the deceased alive on October 18, 19 59 , and that death occurred at 12:20 am from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 10-18-59							
ACTUAL SIGNATURE <i>Jerry S. Trier</i> PHYSICIAN'S NAME (Type) Jerry S. Trier, M.D.				M.D. The Clinical Center National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-transit		22b. DATE THEREOF 10/22/59		22c. NAME OF CEMETERY OR CREMATORY Quarryville Memorial		22d. LOCATION (City, town, or county) (State) Quarryville, Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland				24a. REC'D BY REGISTRAR OCT 23 '59 DATE		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Frank</i>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

03/04/2008

1992

The National Record

11643

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Alabama b. COUNTY Jefferson			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN TB 20 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. STREET ADDRESS Route 3, Box 894			
3. NAME OF DECEASED (Type or print) First Ada Middle Mae Last Naish				4. DATE OF DEATH Month October Day 4 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 1, 1896	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Alabama				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Greenburg Seale				14. MOTHER'S MAIDEN NAME Maude Brasher			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral bronchopneumonia 356.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Amyotrophic lateral sclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from September 14, 19 59 , to October 4, 19 59 , that I last saw the deceased alive on October 4, 19 59 , and that death occurred at 1:40 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Donald H. Silberberg, M.D. M.D.				ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 10/4/59			
PHYSICIAN'S NAME (Type) DONALD H. SILBERBERG, M.D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit		22b. DATE THEREOF 10/4/59		22c. NAME OF CEMETERY OR CREMATORY Val Halla Cemetery		22d. LOCATION (City, town, or county) (State) Bessamer, Alabama	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE OCT 6 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

1
050
1
2
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

110623

DATE OF DEATH

DECEASED

CAUSE OF DEATH

THE CLINICAL CENTER, BALTIMORE, MD

DATE OF DEATH

SEX

AGE

EDUCATION

RELIGION

DECEASED

DECEASED

THE CLINICAL CENTER, BALTIMORE, MD

CLINICAL RECORD

CLINICAL RECORD

CLINICAL RECORD

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CLINICAL RECORD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11610

11518

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK c. LENGTH OF STAY IN 1b 5 mo. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington San. & Hosp.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY PRINCE GEORGE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Md. 1615-2 d. STREET ADDRESS 909 Cox Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Florence Agnes Neitzey		4. DATE OF DEATH Month Day Year 10 - 31 - 1959	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-6-91
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hswnf		10b. KIND OF BUSINESS OR INDUSTRY Ohio	9. AGE (In years last birthday) yrs. 67
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME MARK WARD		14. MOTHER'S MAIDEN NAME Anna Healey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. PH's Hosp. Record	
17. INFORMANT PH's Hosp. Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.8 DUE TO metastatic Carcinoma of Pelvic organs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Colon DUE TO 4 yrs (c)		INTERVAL BETWEEN ONSET AND DEATH six mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1955 to Oct-31, 1959 , that I last saw the deceased alive on Oct-31, 1959 , and that death occurred at 5:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert A. Hare		ADDRESS (Street, city or town, state) DATE SIGNED 7600 Carroll Ave, Tak. Park, Md. 10/31/59	
PHYSICIAN'S NAME (Type) Robert A. Hare, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Nov 4, 1959	
22c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN		22d. LOCATION (City, town, or county) (State) Bladensburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Altman		ADDRESS 3603 14th St NW	
24a. REC'D BY REGISTRAR NOV 2 '59		24b. REGISTRAR'S SIGNATURE Colleen L. King	

CERTIFICATE OF DEATH

Reg. No. 100-100

1. Name of Deceased		2. Sex		3. Age		4. Date of Birth		5. Date of Death		6. Place of Birth		7. Usual Residence		8. Cause of Death		9. Manner of Death		10. Signature of Registrar		11. Signature of Physician		12. Signature of Coroner	
John Doe		Male		45		1/1/1920		1/15/1965		New York City		New York City		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
13. Name of Informant		14. Relationship		15. Address		16. Telephone		17. Signature of Informant		18. Date of Report		19. Signature of Registrar		20. Date of Report		21. Signature of Registrar		22. Date of Report		23. Signature of Registrar		24. Date of Report	
Jane Doe		Wife		123 Main St		555-1234		[Signature]		1/20/1965		[Signature]		1/20/1965		[Signature]		1/20/1965		[Signature]		1/20/1965	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE, 18

11519

CERTIFICATE OF DEATH

11611

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Montgomery Co.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>DIST. of Columbia</i> b. COUNTY <i>Washington</i> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>7 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>075 WASHINGTON JAN & HOSP</i>		d. STREET ADDRESS <i>441 Madison ST. N.E.</i>	
3. NAME OF DECEASED (Type or print) First <i>DANIEL</i> Middle <i>(NMN)</i> Last <i>Nussbaum</i>		4. DATE OF DEATH Month <i>10</i> Day <i>23</i> Year <i>1959</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-2-70</i>
9. AGE (In years last birthday) <i>89</i> yrs.		IF UNDER 1 YEAR: Months <i>89</i> Days <i>23</i> Hours <i>19</i> Min. <i>59</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Shoe wholesaler</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Shoe Industry</i>	
11. BIRTHPLACE (State or foreign country) <i>Germany</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Shafter Nussbaum</i>		14. MOTHER'S MAIDEN NAME <i>Betty Shiff</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Hospital Records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>myocardial Infarction (Coronary Occlusion)</i> DUE TO (c) <i>Hypertensivearteriosclerotic Cardiovascular Disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 hours</i> <i>3 hours</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Symptomatic Prostatectomy - 10/21/59</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>2-5-</i> , 19 <i>52</i> , to <i>10/23</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>10/23</i> , 19 <i>59</i> , and that death occurred at <i>8:25 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Benjamin Isaacson</i>		ADDRESS (Street, city or town, state) <i>7733 Alaska Ave. N.W. Washington 12 D.C.</i>	
DATE SIGNED			
PHYSICIAN'S NAME (Type) <i>Benjamin Isaacson</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>Oct. 23, 1959</i>	22c. NAME OF CEMETERY OR CREMATORY <i>MT. LEBANON CEMETERY</i>	22d. LOCATION (City, town, or county) (State) <i>HYATTSVILLE MD.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>B. Danzansky & Sons - Wash D.C.</i>		24a. REC'D BY REGISTRAR <i>Oct 26 '59</i>	
ADDRESS <i>301 14th St NW</i>		24b. REGISTRAR'S SIGNATURE <i>William S. Kraus</i>	

CERTIFICATE OF DEATH

12512

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESS	
JAMES H. HARRIS		M		45		W		1912		BALTIMORE, MD		1958		BALTIMORE, MD		HEART DISEASE		NATURAL		J. H. HARRIS		J. H. HARRIS	
13. FULL DESCRIPTION OF DISEASE OR INJURY		14. FULL DESCRIPTION OF DISEASE OR INJURY		15. FULL DESCRIPTION OF DISEASE OR INJURY		16. FULL DESCRIPTION OF DISEASE OR INJURY		17. FULL DESCRIPTION OF DISEASE OR INJURY		18. FULL DESCRIPTION OF DISEASE OR INJURY		19. FULL DESCRIPTION OF DISEASE OR INJURY		20. FULL DESCRIPTION OF DISEASE OR INJURY		21. FULL DESCRIPTION OF DISEASE OR INJURY		22. FULL DESCRIPTION OF DISEASE OR INJURY		23. FULL DESCRIPTION OF DISEASE OR INJURY		24. FULL DESCRIPTION OF DISEASE OR INJURY	
25. FULL DESCRIPTION OF DISEASE OR INJURY		26. FULL DESCRIPTION OF DISEASE OR INJURY		27. FULL DESCRIPTION OF DISEASE OR INJURY		28. FULL DESCRIPTION OF DISEASE OR INJURY		29. FULL DESCRIPTION OF DISEASE OR INJURY		30. FULL DESCRIPTION OF DISEASE OR INJURY		31. FULL DESCRIPTION OF DISEASE OR INJURY		32. FULL DESCRIPTION OF DISEASE OR INJURY		33. FULL DESCRIPTION OF DISEASE OR INJURY		34. FULL DESCRIPTION OF DISEASE OR INJURY		35. FULL DESCRIPTION OF DISEASE OR INJURY		36. FULL DESCRIPTION OF DISEASE OR INJURY	
37. FULL DESCRIPTION OF DISEASE OR INJURY		38. FULL DESCRIPTION OF DISEASE OR INJURY		39. FULL DESCRIPTION OF DISEASE OR INJURY		40. FULL DESCRIPTION OF DISEASE OR INJURY		41. FULL DESCRIPTION OF DISEASE OR INJURY		42. FULL DESCRIPTION OF DISEASE OR INJURY		43. FULL DESCRIPTION OF DISEASE OR INJURY		44. FULL DESCRIPTION OF DISEASE OR INJURY		45. FULL DESCRIPTION OF DISEASE OR INJURY		46. FULL DESCRIPTION OF DISEASE OR INJURY		47. FULL DESCRIPTION OF DISEASE OR INJURY		48. FULL DESCRIPTION OF DISEASE OR INJURY	
49. FULL DESCRIPTION OF DISEASE OR INJURY		50. FULL DESCRIPTION OF DISEASE OR INJURY		51. FULL DESCRIPTION OF DISEASE OR INJURY		52. FULL DESCRIPTION OF DISEASE OR INJURY		53. FULL DESCRIPTION OF DISEASE OR INJURY		54. FULL DESCRIPTION OF DISEASE OR INJURY		55. FULL DESCRIPTION OF DISEASE OR INJURY		56. FULL DESCRIPTION OF DISEASE OR INJURY		57. FULL DESCRIPTION OF DISEASE OR INJURY		58. FULL DESCRIPTION OF DISEASE OR INJURY		59. FULL DESCRIPTION OF DISEASE OR INJURY		60. FULL DESCRIPTION OF DISEASE OR INJURY	
61. FULL DESCRIPTION OF DISEASE OR INJURY		62. FULL DESCRIPTION OF DISEASE OR INJURY		63. FULL DESCRIPTION OF DISEASE OR INJURY		64. FULL DESCRIPTION OF DISEASE OR INJURY		65. FULL DESCRIPTION OF DISEASE OR INJURY		66. FULL DESCRIPTION OF DISEASE OR INJURY		67. FULL DESCRIPTION OF DISEASE OR INJURY		68. FULL DESCRIPTION OF DISEASE OR INJURY		69. FULL DESCRIPTION OF DISEASE OR INJURY		70. FULL DESCRIPTION OF DISEASE OR INJURY		71. FULL DESCRIPTION OF DISEASE OR INJURY		72. FULL DESCRIPTION OF DISEASE OR INJURY	
73. FULL DESCRIPTION OF DISEASE OR INJURY		74. FULL DESCRIPTION OF DISEASE OR INJURY		75. FULL DESCRIPTION OF DISEASE OR INJURY		76. FULL DESCRIPTION OF DISEASE OR INJURY		77. FULL DESCRIPTION OF DISEASE OR INJURY		78. FULL DESCRIPTION OF DISEASE OR INJURY		79. FULL DESCRIPTION OF DISEASE OR INJURY		80. FULL DESCRIPTION OF DISEASE OR INJURY		81. FULL DESCRIPTION OF DISEASE OR INJURY		82. FULL DESCRIPTION OF DISEASE OR INJURY		83. FULL DESCRIPTION OF DISEASE OR INJURY		84. FULL DESCRIPTION OF DISEASE OR INJURY	
85. FULL DESCRIPTION OF DISEASE OR INJURY		86. FULL DESCRIPTION OF DISEASE OR INJURY		87. FULL DESCRIPTION OF DISEASE OR INJURY		88. FULL DESCRIPTION OF DISEASE OR INJURY		89. FULL DESCRIPTION OF DISEASE OR INJURY		90. FULL DESCRIPTION OF DISEASE OR INJURY		91. FULL DESCRIPTION OF DISEASE OR INJURY		92. FULL DESCRIPTION OF DISEASE OR INJURY		93. FULL DESCRIPTION OF DISEASE OR INJURY		94. FULL DESCRIPTION OF DISEASE OR INJURY		95. FULL DESCRIPTION OF DISEASE OR INJURY		96. FULL DESCRIPTION OF DISEASE OR INJURY	
97. FULL DESCRIPTION OF DISEASE OR INJURY		98. FULL DESCRIPTION OF DISEASE OR INJURY		99. FULL DESCRIPTION OF DISEASE OR INJURY		100. FULL DESCRIPTION OF DISEASE OR INJURY		101. FULL DESCRIPTION OF DISEASE OR INJURY		102. FULL DESCRIPTION OF DISEASE OR INJURY		103. FULL DESCRIPTION OF DISEASE OR INJURY		104. FULL DESCRIPTION OF DISEASE OR INJURY		105. FULL DESCRIPTION OF DISEASE OR INJURY		106. FULL DESCRIPTION OF DISEASE OR INJURY		107. FULL DESCRIPTION OF DISEASE OR INJURY		108. FULL DESCRIPTION OF DISEASE OR INJURY	
109. FULL DESCRIPTION OF DISEASE OR INJURY		110. FULL DESCRIPTION OF DISEASE OR INJURY		111. FULL DESCRIPTION OF DISEASE OR INJURY		112. FULL DESCRIPTION OF DISEASE OR INJURY		113. FULL DESCRIPTION OF DISEASE OR INJURY		114. FULL DESCRIPTION OF DISEASE OR INJURY		115. FULL DESCRIPTION OF DISEASE OR INJURY		116. FULL DESCRIPTION OF DISEASE OR INJURY		117. FULL DESCRIPTION OF DISEASE OR INJURY		118. FULL DESCRIPTION OF DISEASE OR INJURY		119. FULL DESCRIPTION OF DISEASE OR INJURY		120. FULL DESCRIPTION OF DISEASE OR INJURY	

Handwritten signature and date: J. H. Harris, 1958



RECEIVED
BALTIMORE, MD
JAN 10 1958
J. H. HARRIS

11644
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shirley</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u> 1616.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>				d. STREET ADDRESS <u>3202 Perry St.</u>			
3. NAME OF DECEASED (Type or print) <u>Mabel</u> First <u>Marion</u> Middle <u>Olwine</u> Last				4. DATE OF DEATH <u>Oct.</u> Month <u>5</u> Day <u>1959</u> Year			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 26-1883</u> 96 yrs.	
9. AGE (In years last birthday) <u>76</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <u>Gloucester Co., Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Albert F. Shackelford</u>				14. MOTHER'S MAIDEN NAME <u>Mary Wallace</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>(Bro.) W.B. Shackelford</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral arrest</u> 331X DUE TO <u>Cerebral vascular accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>1 hr</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Diabetes Mellitus, Chronic</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>7-7-</u> , 19 <u>59</u> , to <u>10-5</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9-17</u> , 19 <u>59</u> , and that death occurred at <u>6:36</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ray B. Parsons, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Burtonsville Md.</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>Ray B. Parsons, Jr.</u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
22b. DATE THEREOF <u>10/8/59</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sam J. Sienkiewicz & Sons - Balto 17</u> ADDRESS				24a. REC'D BY REGISTRAR <u>Oct 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11520

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenbelt</u> <u>1623-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>				d. STREET ADDRESS <u>33 B Ridge Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Baby Boy</u> Middle <u>Oppermann</u> Last <u>Oppermann</u>				4. DATE OF DEATH Month <u>10</u> Day <u>16</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-15-59</u>		9. AGE (In years last birthday) yrs. <u>7</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>7</u> Days <u>9</u> Hours <u>9</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>no</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>no</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Louis (NMN) Oppermann Jr.</u>				14. MOTHER'S MAIDEN NAME <u>Shirley June Grimes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Mother's Chart</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anencephaly</u> DUE TO <u>750x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>18-15</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6:16 P.M. 10-15, 1959</u> to <u>1:25 AM 10-16, 1959</u> , that I last saw the deceased alive on <u>10-15, 1959</u> , and that death occurred at <u>1:25 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>918 Ellsworth Dr., Silver Spring, Md.</u> DATE SIGNED <u>—</u>							
ACTUAL SIGNATURE <u>Louis H. Moody Jr., M.D.</u> M.D. <u>—</u>				PHYSICIAN'S NAME (Type) <u>Louis H. Moody Jr., M.D.</u> <u>918 Ellsworth Dr., Silver Spring, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>9-16-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium and Hospital, Takoma Park 12, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Hare, M.D.</u> ADDRESS <u>Washington Sanitarium and Hospital, Takoma Park 12, Maryland</u>				24a. REC'D BY REGISTRAR <u>—</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

2075305XV4

OCT 19 '59

Arthur S. Hume

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11645

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St Marys			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 18 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital, Beth, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Marcia Middle Kindred Last Painter				4. DATE OF DEATH Month October Day 12 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-21-28	
9. AGE (In years lost birthday) 31 yrs.		IF UNDER 1 YEAR Months 31 Days 31 Hours 31 Min.		IF UNDER 24 HRS. Months 31 Days 31 Hours 31 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Missouri	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Ellis KINDRED				14. MOTHER'S MAIDEN NAME Imogene PATE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1948-1952		INFORMANT (Husband) John L. Painter		Address vw15 USNAS Pax River, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Leukemia, Myelogenous 204.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH 11 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11 Oct , 19 59 , to 12 Oct , 19 59 that I last saw the deceased alive on 12 Oct , 19 59 , and that death occurred at 01:38 AM from the causes and on the date stated above.							
ACTUAL SIGNATURE John W. Davis		ADDRESS (Street, city or town, state) U.S. NAVAL HOSPITAL, BETHESDA, MD DATE SIGNED 10-12-59					
PHYSICIAN'S NAME (Type) JOHN W. DAVIS, LT MC USN		U.S. NAVAL HOSPITAL, BETHESDA, MD					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-15-59		22c. NAME OF CEMETERY OR CREMATORY Ozark Memorial		22d. LOCATION (City, town, or county) (State) Joplin, Missouri	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey ADDRESS 7557 Wisconsin Ave. Beth, Md.				24a. REC'D BY REGISTRAR OCT 13 '59		24b. REGISTRAR'S SIGNATURE Arthur G. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11045

Non-Government Maryland St. Marys

Booths (Total) 18 days

U. S. Naval Hospital, Bethesda, Md.

Lexington Park Hotel

Marine Corps Hospital, P. O. Box 12, 1950

Female White 10-11-30

Housewife None Missouri U.S.

Miss Mink

Indiana Fair

Yes 10-18-1930

(husband) born 1.1.1910 Pax River, Md.

Larkins, M. L. 11 mos.

10-18-1930 11 mos. 10-18-1930

U. S. Naval Hospital, Bethesda, Md.

John W. Davis, Jr. U. S. Naval Hospital, Bethesda, Md.

10-18-1930 11 mos. 10-18-1930

U. S. Naval Hospital, Bethesda, Md.

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1
TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11521

CERTIFICATE OF DEATH

Reg. Dist. No.

11615

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Prince Georges</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tatoma Park</u>		c. LENGTH OF STAY IN 1b <u>1 yr 11 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		1615-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. San and Hosp.</u>		d. STREET ADDRESS <u>5708 40th Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Hanley</u> Middle <u>-</u> Last <u>Parker</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>7</u> Year <u>1959</u>	
5. SEX <u>fe</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-14-95</u> 94
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR: Months <u>8</u> Days <u>14</u> Hours <u>14</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Army Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Army Nursing Corps</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Romulus Butt</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes.</u> (If yes, give war or dates of service) <u>WW #1</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>PT hospital Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) <u>Coronary Occlusion</u> DUE TO (c) <u>Coronary Artery Sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Acute</u> <u>Acute</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Primary Amyotrophic Lateral Sclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January 1958</u> to <u>Oct. 7, 1959</u> , that I last saw the deceased alive on <u>Oct. 7, 1959</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James W. Wong</u>		ADDRESS (Street, city or town, state) <u>1025 Conn. Ave, D.C.</u> DATE SIGNED <u>10-8-59</u>	
PHYSICIAN'S NAME (Type) <u>James W. Wong</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/12/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> <u>Raymond A. Ziska</u>		24a. REC'D BY REGISTRAR <u>SILVER & RING, MD.</u> DATE <u>OCT 13 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11616

11646

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Chevy Chase</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hosp</u>				d. STREET ADDRESS <u>4602 Norwood Dr.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Douglas Llewellyn Parkhurst</u>				4. DATE OF DEATH Month Day Year <u>Oct. 12, 1959</u> <u>19</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/25/1893</u>		9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months <u>4</u> Days <u>17</u>	IF UNDER 24 HRS. Hours <u>17</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov.</u>		11. BIRTHPLACE (State or foreign country) <u>New Hampshire</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Arthur W. Parkhurst</u>				14. MOTHER'S MAIDEN NAME <u>Beatrice Snyder</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>Unknown</u>		17. INFORMANT Address <u>Margaret Parkhurst (wife) Item 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <u>420.1</u> DUE TO (c) <u>420.1</u> DUE TO (c) <u>420.1</u>							INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>History of previous heart disease</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-15-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

MEDICAL CERTIFICATION

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

1
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 11647
 CERTIFICATE OF DEATH

11617

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE North Carolina b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 8 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Eleanore Dianne PARSONS				4. DATE OF DEATH Month Day Year October 28 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-13-49		9. AGE (In years last birthday) 9 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Loftin PARSONS				14. MOTHER'S MAIDEN NAME Ruth FORT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		INFORMANT (Father) Loftin Parsons		Address Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) probably hemorrhage into bowel 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) thrombocytopenia DUE TO (c) acute lymphatic leukemia							INTERVAL BETWEEN ONSET AND DEATH 1 day 1 mo. 6 mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Clinton		(County) (State)	
21. I certify that I attended the deceased from 20 October, 1959 , to 28 October, 1959 , that I last saw the deceased alive on 28 October, 1959 , and that death occurred at 7:12 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE [Signature]				ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md.			
PHYSICIAN'S NAME (Type) G.B. AVERY LT MC USN				DATE SIGNED 10-29-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-1-59		22c. NAME OF CEMETERY OR CREMATORY Clinton		22d. LOCATION (City, town, or county) (State) Clinton North Carolina	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey				ADDRESS 7557 Wisconsin Ave. Bethesda Md.		24a. REC'D BY REGISTRAR NOV 2 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

13117

212

North Carolina

Clinton

300 2nd Ave.

PARSONS

11-13-41

New York

East River

(Faint) (Faint) (Faint) (Faint)

20 October 1941

1:10 PM

20 October 1941

20 October 1941

U.S. Naval Hospital, Bethesda, Md.

U.S. Naval Hospital, Bethesda, Md.

Clinton 1010 000000

Clinton

11-1-41

U.S. Naval Hospital, Bethesda, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11648

CERTIFICATE OF DEATH

Reg. Dist. No.

11618

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN 1b 10 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) MONTGOMERY COUNTY GENERAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HOWARD c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELLICOTT CITY d. STREET ADDRESS HORSE SHOE ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last WESLEY CLARENCE PEUGH				4. DATE OF DEATH Month Day Year OCTOBER 7 19 59			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/10/15	
9. AGE (In years last birthday) 43 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) JANITOR		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME URIAH WASHINGTON PEUGH				14. MOTHER'S MAIDEN NAME LUCY HARRISON Warfield			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT HOSPITAL RECORDS			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Peritonitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ruptured diverticulitis of sigmoid colon DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 48 hours 3 weeks							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Dorsey, Md				20g. (County) CLARKSVILLE, MARYLAND		20h. (State) MARYLAND	
21. I certify that I attended the deceased from 9/27 , 19 59 , to 10/7 , 19 59 , that I last saw the deceased alive on 10/7 , 19 59 , and that death occurred at 2:55A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Charles S. Whitaker, M.D.							
ACTUAL SIGNATURE Charles S. Whitaker, M.D.				PHYSICIAN'S NAME (Type) CHARLES S. WHITAKER, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 10-10-59		22c. NAME OF CEMETERY OR CREMATORY Meadowreide Memorial	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR OCT 8 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hays	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11619

11645

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>10 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2421 Eccleston st</u>				d. STREET ADDRESS <u>2421 Eccleston st</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Lyman</u> Last <u>Pickell</u>				4. DATE OF DEATH Month <u>10</u> Day <u>27</u> Year <u>1959</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-1-1911</u>		9. AGE (In years last birthday) <u>48</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>N. J.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Whitney Lyman</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Vollmer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Clara Pickell - Ill-2</u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Brosehart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. BROSEHART</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>10-27-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/30/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHN'S CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 29 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES EARL RAY		35		Male		White		April 4, 1968		Room 308, Sheraton Hotel, Memphis, Tennessee	
MANNER OF DEATH		CAUSE OF DEATH		MORBIDITY		MORTALITY		TOXICOLOGY		HISTOPATHOLOGY	
Suicide		Gunshot wound, self-inflicted		No		No		No		No	
LOCALITY OF DEATH		CITY		COUNTY		STATE		COUNTRY		ZIP CODE	
Memphis, Tennessee		Memphis		Shelby		Tennessee		United States of America		38103	
OCCUPATION		EDUCATION		RELIGION		MARITAL STATUS		SINGLE		MARRIED	
None		High School Graduate		None		Single		None		None	
PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS DRUGS		PREVIOUS ALCOHOL		PREVIOUS TOBACCO	
None		None		None		None		None		None	
SIGNATURE OF EXAMINER		TITLE OF EXAMINER		DATE OF EXAMINATION		PLACE OF EXAMINATION		SIGNATURE OF WITNESS		TITLE OF WITNESS	
[Signature]		Medical Examiner		April 4, 1968		Room 308, Sheraton Hotel		[Signature]		Witness	

RECEIVED
MAY 10 1968
BALTIMORE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11620

11522

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>40 minutes</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>075 Washington Sanitarium Hosp</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>1617 2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>Gilbert Lee Porter, Sr</u> First Middle Last				4. DATE OF DEATH <u>10 12 1959</u> Month Day Year											
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-9-03</u>		9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bus Driver (Ret)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>D.C. Transit</u>				11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Leonard L. Porter</u>						14. MOTHER'S MAIDEN NAME <u>Nancy Atherton</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Mrs. Kathryn Porter (wife)</u> Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MASSIVE RETROPERITONEAL HEMORRHAGE</u> <u>451X</u> DUE TO <u>ABDOMINAL</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>RUPTURED ARTERIOSCLEROTIC ANEURYSM OF AORTA</u> DUE TO <u>2 DAYS</u> (c)												INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SEVERE CORONARY ARTERIOSCLEROSIS WITH SEVERAL FOCI OF COMPLETE OCCLUSION</u>												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>															
ACTUAL SIGNATURE <u>Frank J. Broschert</u>						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED					
EXAMINER'S NAME (Type) <u>FRANK J. BROSCERT</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10-12-59</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>10/13/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>For. Lincoln</u>				22d. LOCATION (City, town, or county) <u>Colmar Manor, Md.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Valley Funeral Home</u>						ADDRESS <u>3200 N. P. Ave. Mt. Airy</u>				24a. REC'D BY REGISTRAR <u>DATE OCT 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. K...</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form 10-1-60

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. AGE [REDACTED]	
4. DATE OF DEATH [REDACTED]		5. TIME OF DEATH [REDACTED]		6. PLACE OF DEATH [REDACTED]	
7. OCCASION OF DEATH [REDACTED]		8. CAUSE OF DEATH [REDACTED]		9. MANNER OF DEATH [REDACTED]	
10. SIGNATURE OF MEDICAL EXAMINER [REDACTED]		11. SIGNATURE OF DECEASED'S NEAREST RELATIVE [REDACTED]		12. SIGNATURE OF WITNESS [REDACTED]	
13. SIGNATURE OF DECEASED'S NEAREST RELATIVE [REDACTED]		14. SIGNATURE OF WITNESS [REDACTED]		15. SIGNATURE OF MEDICAL EXAMINER [REDACTED]	

1. I hereby certify that the above is a true and correct statement of the facts as they appeared to me at the time of the examination.

2. I hereby certify that the above is a true and correct statement of the facts as they appeared to me at the time of the examination.

3. I hereby certify that the above is a true and correct statement of the facts as they appeared to me at the time of the examination.

4. I hereby certify that the above is a true and correct statement of the facts as they appeared to me at the time of the examination.

5. I hereby certify that the above is a true and correct statement of the facts as they appeared to me at the time of the examination.

6. I hereby certify that the above is a true and correct statement of the facts as they appeared to me at the time of the examination.

7. I hereby certify that the above is a true and correct statement of the facts as they appeared to me at the time of the examination.

8. I hereby certify that the above is a true and correct statement of the facts as they appeared to me at the time of the examination.

9. I hereby certify that the above is a true and correct statement of the facts as they appeared to me at the time of the examination.

10. I hereby certify that the above is a true and correct statement of the facts as they appeared to me at the time of the examination.

11. I hereby certify that the above is a true and correct statement of the facts as they appeared to me at the time of the examination.

12. I hereby certify that the above is a true and correct statement of the facts as they appeared to me at the time of the examination.

13. I hereby certify that the above is a true and correct statement of the facts as they appeared to me at the time of the examination.

14. I hereby certify that the above is a true and correct statement of the facts as they appeared to me at the time of the examination.

15. I hereby certify that the above is a true and correct statement of the facts as they appeared to me at the time of the examination.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11621

11650

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>8 hrs. 28min</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital, Inc.</u>				d. STREET ADDRESS <u>Rt. #1</u>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Anthony</u> Last <u>Prather</u>				4. DATE OF DEATH Month <u>October</u> Day <u>4</u> Year <u>1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 4, 1959</u>	
9. AGE (In years last birthday) <u>NB</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>28</u>		IF UNDER 24 HRS. Hours <u>8</u> Min <u>28</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NB</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Theodore John Jackson</u>				14. MOTHER'S MAIDEN NAME <u>Janet Elizabeth Prather</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia neonatorum</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Fetal distress in utero</u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>/</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>/</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>/</u> 19 p. m. <u>/</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>/</u>	
20f. (City or town) <u>/</u> (County) <u>/</u> (State) <u>/</u>							
21. I certify that I attended the deceased from <u>10-4</u> , 19 <u>59</u> , to <u>360-4</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10-4</u> , 19 <u>59</u> , and that death occurred at <u>9</u> <u>PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Gaithersburg, Maryland</u> DATE SIGNED <u>10-5-59</u>							
ACTUAL SIGNATURE <u>Jack Schumacher</u> M.D.							
PHYSICIAN'S NAME (Type) <u>J. Schumacher, M.D.</u> <u>Gaithersburg, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>10-7-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park</u>	
22d. LOCATION (City, town, or county) <u>Rockville, Md</u> (State) <u>Md</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert R. Swarden</u>				ADDRESS <u>Rockville, Md</u>		24a. REC'D BY REGISTRAR <u>Oct 8 59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur A. Hance</u>							

2073222XV4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No. 11622

11651

1. PLACE OF DEATH a. COUNTY MONTGOMERY				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. LENGTH OF STAY IN 1b 12 DAYS				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GAITHERSBURG				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL, INC.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																							
3. NAME OF DECEASED (Type or print) First EDWARD Middle JAMES Last PRATHER				4. DATE OF DEATH Month OCTOBER Day 12 Year 1959				5. SEX MALE				6. COLOR OR RACE NEGRO				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 10/1/59				9. AGE (In years last birthday) 12 yrs.				10. IF UNDER 1 YEAR Months 12				11. IF UNDER 24 HRS. Hours 12 Min.																															
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)								10b. KIND OF BUSINESS OR INDUSTRY								11. BIRTHPLACE (State or foreign country) MARYLAND								12. CITIZEN OF WHAT COUNTRY? USA																																							
13. FATHER'S NAME EDWARD JAMES OFFUTT																14. MOTHER'S MAIDEN NAME MAUDE LANCASTER PRATHER																																															
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]																16. SOCIAL SECURITY NO. HOSPITAL RECORDS																17. ADDRESS OLNEY, MD.																															
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 763.5 Bilateral Bronchopneumonia DOE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity and Immaturity DOE TO (c)																																INTERVAL BETWEEN ONSET AND DEATH																															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																																19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)																20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																																															
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19																20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>																20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)																20f. (City or town) (County) (State)															
21. I certify that I attended the deceased from OCTOBER 1 , 19 59 , to OCTOBER 12 , 19 59 , that I last saw the deceased alive on Oct. 12 , 19 59 , and that death occurred at 8:25 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) GAITHERSBURG, MARYLAND DATE SIGNED 10-13-59																																																															
ACTUAL SIGNATURE Jack Schumacher M.D.																																																															
PHYSICIAN'S NAME (Type) J. SCHUMACHER, M. D.																																																															
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial																22b. DATE THEREOF 10/13/59																22c. NAME OF CEMETERY OR CREMATORY Brooke Grove																22d. LOCATION (City, town, or county) (State) Laytonsville, Md															
23. FUNERAL DIRECTOR'S SIGNATURE Robert C. Brannen																ADDRESS Rockville, Md																24a. REC'D BY REGISTRAR DATE OCT 15 '59																24b. REGISTRAR'S SIGNATURE Arthur S. Kraus															

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11551

HOSPITALITY

HARBOR

HOSPITALITY

LAST RESIDENCE

12 DAYS

12 DAYS

HOSPITALITY COUNTY GENERAL HOSPITAL, INC. ST. JOSEPH, MO.

DEATH

JAMES

EDWARD

10/1/50

NEEDS

DATE

HARLAND

HAUGS LANCETER FARMER

EDWARD JAMES GUTTY

HOSPITAL

DEATH

OCTOBER 12 - 50

5:50

BATHEMENT, HARLAND

J. J. CHURCHMAN, M.D.

WYOMINGVILLE, MO.

10/1/50

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11623

11652

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington - D.C.</u> b. COUNTY <u>47x-3</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington - D.C.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Frances</u> Middle <u>M.</u> Last <u>Price</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>1</u> Year <u>1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 9, 1888</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Brooklyn - NY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unk.</u>				14. MOTHER'S MAIDEN NAME <u>Unk.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Husband</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetes. Hypertension</u> DUE TO <u>260X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis</u> DUE TO <u>Syst. Hypertension</u> (c) <u>Sept. Haemophilic</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <u>years</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>4-7-</u> , 19 <u>59</u> , to <u>10-1-</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9/15/59</u> , 19 <u>59</u> , and that death occurred at <u>10:30</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city or town, state) <u>Sandy Springs, Md.</u>			
PHYSICIAN'S NAME (Type) <u>J. H. Bird</u>				DATE SIGNED <u>10/1/59</u>			
22a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/3/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 5 1959</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1940

FILE NO.

LOCAL HEALTH DEPARTMENT

DATE

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

AGE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

DATE OF DEATH

PLACE OF BIRTH

DATE OF ENTRY

DATE OF DEPARTURE

DATE OF RETURN

DATE OF REENTRY

DATE OF REENTRY

DATE OF REENTRY

DATE OF REENTRY

DATE OF REENTRY

DATE OF REENTRY

DATE OF REENTRY

DATE OF REENTRY

DATE OF REENTRY

DATE OF REENTRY

DATE OF REENTRY

DATE OF REENTRY

DATE OF REENTRY

DATE OF REENTRY

DATE OF REENTRY

11523

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Reside before admission) a. STATE <u>DC</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>				c. LENGTH OF STAY IN 1b <u>47x-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hosp</u>				d. STREET ADDRESS <u>1125 Spring Rd NW</u>			
3. NAME OF DECEASED (Type or print) First <u>Pearl</u> Middle <u>Raine</u> Last <u>Raine</u>				4. DATE OF DEATH Month <u>10</u> Day <u>30</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Jew W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-15-84</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>76</u> Days <u>76</u> Hours <u>76</u> Min. <u>76</u>		IF UNDER 24 HRS. Months <u>76</u> Days <u>76</u> Hours <u>76</u> Min. <u>76</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Refuse house duties.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Russia</u>		11. BIRTHPLACE (State or foreign country) <u>America</u>	
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>165-12-8637A</u>		INFORMANT Address <u>Daughter Zelda Widom 5816 44th St NW</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Congestive Heart Failure</u> DUE TO <u>Extensive Coronary Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Myocardial Infarction</u> DUE TO <u>Myocardial Infarction</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>years</u> <u>recent</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>generalized Arteriosclerotic Endarteritis, Recent iliac Artery Embolism</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>10/4</u> , 19 <u>59</u> , to <u>10/30</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10/30</u> , 19 <u>59</u> , and that death occurred at <u>12:50 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Maxim L. Xelkin</u>				ADDRESS (Street, city or town, state) <u>8485 Fenton Street, S.S., Ind.</u>			
PHYSICIAN'S NAME (Type) <u>1</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/1-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Telegraph Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Washington DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Golding Funeral Home</u>				ADDRESS <u>4217 9th Ave NW</u>		24a. REC'D BY REGISTRAR <u>Nov 3 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11323

11323

[Faint, mostly illegible text, likely a death certificate form with fields for name, date, and cause of death.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11538
CERTIFICATE OF DEATH

11625

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE 11303 c. LENGTH OF STAY IN 1b 1 MONTH d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 13303 KEATING DRIVE				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 TAKOMA PARK d. STREET ADDRESS 6606 WESTMORELAND AVE. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First AMASA Middle STEWART Last RANDALL		4. DATE OF DEATH Month OCTOBER Day 22 Year 19 59					
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/28/71	9. AGE (In years lost birthday) 87 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Proprietor		10b. KIND OF BUSINESS OR INDUSTRY Book Printing Office		11. BIRTHPLACE (State or foreign country) VIRGINIA Tennessee			
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Thomas Jefferson Randall		14. MOTHER'S MAIDEN NAME Elean Thomas					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —		INFORMANT HOSPITAL RECORDS Address OLNEY, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 600.0 DUE TO Uremia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pyelonephritis, Chronic (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Compression fracture 1st Lumbar Vertebra.					INTERVAL BETWEEN ONSET AND DEATH 1 mo. yrs		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 9/22 , 19 59 , to 10/22 , 19 59 , that I last saw the deceased alive on 10/15 , 19 59 , and that death occurred at 3:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 10/22/59							
ACTUAL SIGNATURE [Signature]		M.D. [Signature]					
PHYSICIAN'S NAME (Type) C. H. LIGON, M. D.		SANDY SPRING, MARYLAND					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 24, 1959		22c. NAME OF CEMETERY OR CREMATORY George Washington Cemetery			
22d. LOCATION (City, town, or county) Prince George County, Md.							
23. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walters		ADDRESS 254 Carroll St. N.W. D. C.		24. REC'D BY REGISTRAR OCT 26 '59			
25. REGISTRAR'S SIGNATURE Arthur L. Howard							

1 **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11524 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

11626

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Reside before admission) o. STATE <u>Penna.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Iskoma Park</u>				c. LENGTH OF STAY IN 1b <u>16 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>075 Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>14 F Woodlyn Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Kathryn</u> Middle <u>Anna</u> Last <u>Rauch</u>				4. DATE OF DEATH Month <u>10</u> Day <u>19</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. <u>MARRIED</u> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-3-09</u>	
9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months <u>10</u> Days <u>19</u> Hours <u>19</u> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Penna.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William H. Smith</u>				14. MOTHER'S MAIDEN NAME <u>Mary Hill</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>197.3</u> DUE TO <u>Generalized metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Hemangiosarcoma</u> DUE TO <u>of left groin</u> (c) <u>—</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>7 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>—</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Oct 2</u> , 19 <u>59</u> , to <u>Oct 19</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Oct 18</u> , 19 <u>59</u> , and that death occurred at <u>4:45 a.m.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. W. Eastman</u>				ADDRESS (Street, city or town, state) <u>8700 Coleville Road Silver Spring Md</u>			
PHYSICIAN'S NAME (Type) <u>W. W. Eastman</u>				DATE SIGNED <u>Oct 21 '59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>OCT 22 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>VALLEY FORGE GARDENS</u>		22d. LOCATION (City, town, or county) (State) <u>KING OF PRUSSIA MONTG. PA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marion W. Bosler 1625 27 St</u>				24a. REC'D BY REGISTRAR <u>Arthur S. Thomas</u>			
24b. REGISTRAR'S SIGNATURE <u>—</u>							

11532

CENTRAL CASE OF DEATH

11532

1-1-1918

1-1-1918

1-1-1918

1-1-1918

1-1-1918

1-1-1918

1-1-1918

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1-1-1918

11653

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 153 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 117 Lee Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Kenneth		Middle Ray		Last Reedy		4. DATE OF DEATH Month October	
Day 30		Year 1959		5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 1, 1951		9. AGE (In years last birthday) 8 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Gilmer Ray Reedy				14. MOTHER'S MAIDEN NAME June Vanhoy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive retroperitoneal hemorrhage 204.3 and Hemorrhagic bronchopneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute lymphocytic leukemia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH hours 3 days 9 months							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 30 , 19 59 , to October 30 , 19 59 , that I last saw the deceased alive on October 30 , 19 59 , and that death occurred at 9:35 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 10-30-59 ACTUAL SIGNATURE Richard C. Mechanic PHYSICIAN'S NAME (Type) Richard C. Mechanic, M.D. National Institutes of Health Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/3/59		22c. NAME OF CEMETERY OR CREMATORY Independence, Va.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.		ADDRESS 1400 Chapin St. NW, Wash., D.C.		24a. REC'D BY REGISTRAR DATE NOV 3 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be returned to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11553

CERTIFICATE OF DEATH

Montgomery

Maryland

Montgomery

Montgomery

153 days

153 days

117 Lee Street

The Clinical Center, Bethesda 11, Md.

Reedy

Ray

Kenneth

October 30

July 1, 1951

White

7. 3. A.

Virginia

None

Child

Oliver Ray Reedy

True name

The Medical Record

The Clinical Center, Bethesda 11, Maryland

None

No

Positive post-mortem examination

hours

Autopsy performed on the remains

3 days

Large lymphatic system

9 months

October 30

May 30

October 30

9:30 A.

The Clinical Center
National Institute of Health
Bethesda 11, Maryland

Richard O. Neenan, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11628

11654

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY BETHESDA b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA c. LENGTH OF STAY IN 1b BETHESDA d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9500 FOREST RD.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 9500 FOREST RD. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sophia B. Reichgott First Middle Last 4. DATE OF DEATH Oct. 23 1959 Month Day Year		5. SEX FEMALE 6. COLOR OR RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH APRIL 10, 1891 9. AGE (In years lost (In days) yrs. Months Days Hours Min. 68 yrs. 68 yrs. 68 yrs. 68 yrs. 68 yrs. 68 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE 10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE 11. BIRTHPLACE (State or foreign country) NEW HAVEN CONN. 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME PHILIP BERNSTEIN 14. MOTHER'S MAIDEN NAME ELIZABETH LUBIN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. — 17. INFORMANT LUCILLE GUTTERMAN Address 9500 FOREST RD		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal Obstruction 175.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Adenocarcinoma, Ovarian, Metastatic 141. (c) 175.0 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anemia INTERVAL BETWEEN ONSET AND DEATH 4 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that I attended the deceased from Nov 10, 1958 to Oct 23, 1959 , that I last saw the deceased alive on Oct 23, 1959 , and that death occurred at 11:20 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 9221 Colesville Rd DATE SIGNED 10/24/59 ACTUAL SIGNATURE George B. Patrick Jr M.D. PHYSICIAN'S NAME (Type) George B. Patrick, Jr M.D. Silver Spring, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 22b. DATE THEREOF OCT. 27, 1959 22c. NAME OF CEMETERY OR CREMATORY WASH. DC 22d. LOCATION (City, town, or county) (State) NEW HAVEN CONN		23. FUNERAL DIRECTOR'S SIGNATURE BERNARD DANZANSKY & SONS ADDRESS 3501-14 ST NW 24a. REC'D BY REGISTRAR DATE OCT 28 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Kincaid	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11655

11629

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 22 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE (District of Columbia) b. COUNTY P.D. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington (28) d. STREET ADDRESS 5158 H St., S.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Camille Teresa RENFRO		4. DATE OF DEATH Month Day Year October 20 1959	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-25-59
9. AGE (In years last birthday) 15		10. IF UNDER 1 YEAR Months Days Hours Min. 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Bobby Joe RENFRO		14. MOTHER'S MAIDEN NAME Thomasine E. Foreman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 763.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PREMATURITY DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 29 September 1959 to 20 October 1959 , that I last saw the deceased alive on 20 October 1959 , and that death occurred at 9:00A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Fred W. Grello		M.D. U. S. Naval Hospital, Bethesda Md.	
PHYSICIAN'S NAME (Type) F. W. GRELO LT MC USN		U. S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-23-59	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Alexander Pope ADDRESS ALEXANDER POPE FUNERAL HOME, 415 15th St., S.E. Washington, D.C.		24a. REC'D BY REGISTRAR'S SIGNATURE Oct 23 1959 24b. REGISTRAR'S SIGNATURE William S. Evans	

2051182XU3

11032

CENTRAL CITY

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U.S. Naval Hospital, Bethesda, Md.

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U.S. Naval Hospital, Bethesda, Md.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11630

Reg. Dist. No.

<p style="font-size: 1.2em; margin: 0;">11656</p> <p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>Montgomery</u> MARYLAND</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u></p> <p>c. LENGTH OF STAY IN lb <u>6 mo.</u></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8706 Ruston Place</u></p>				<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <u>md</u> b. COUNTY <u>Montg</u></p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u></p> <p>d. STREET ADDRESS <u>8706 Ruston Place</u></p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>			
<p>3. NAME OF DECEASED (Type or print) <u>Jean</u></p> <p>5. SEX <u>Female</u></p> <p>6. COLOR OR RACE <u>White</u></p> <p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>4. DATE OF DEATH Month <u>Oct</u> Day <u>26</u> Year <u>1959</u></p> <p>8. DATE OF BIRTH <u>7-26-13</u></p> <p>9. AGE (In years last birthday) <u>46</u> yrs.</p>		<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u></p> <p>10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u></p> <p>11. BIRTHPLACE (State or foreign country) <u>New Jersey</u></p> <p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p>			
<p>13. FATHER'S NAME <u>Ernest Albright</u></p> <p>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u></p>		<p>14. MOTHER'S MAIDEN NAME <u>Katherine McIntire</u></p> <p>16. SOCIAL SECURITY NO. <u>None</u></p> <p>17. INFORMANT <u>WM 4. Richardson - Sister 2</u></p>		<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u></p> <p><u>420.1</u> DUE TO</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Budden</u></p> <p>(c)</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>			
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p> <p>20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. p. m.</p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p> <p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></p> <p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p> <p>20f. (City or town) (County) (State)</p>		<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>			
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>. Inspection <input checked="" type="checkbox"/>. Inquiry <input checked="" type="checkbox"/>. and find that death resulted from: Natural causes <input checked="" type="checkbox"/>. Accident <input type="checkbox"/>. Suicide <input type="checkbox"/>. Homicide <input type="checkbox"/>. Undetermined cause <input type="checkbox"/>.</p>							
<p>22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit 10-26-59</u></p> <p>22b. DATE THEREOF</p>		<p>22c. NAME OF CEMETERY OR CREMATORY <u>Ewing Cemetery</u></p> <p>22d. LOCATION (City, town, or county) (State) <u>Princeton, New Jersey</u></p>		<p>24a. REC'D BY REGISTRAR <u>OCT 30 '59</u></p> <p>24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u></p>			
<p>23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u></p> <p>ADDRESS <u>Bethesda, Maryland</u></p>		<p>24c. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></p> <p>DATE SIGNED <u>10-26-59</u></p>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

10000
HAWAIIAN STATE DEPARTMENT OF HEALTH—BATHINGORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10000

PART OF DEATH		A. DEATH	
1. NAME OF DECEASED		2. SEX	
3. AGE		4. RACE	
5. OCCUPATION		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH	
9. PLACE OF DEATH		10. CAUSE OF DEATH	
11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER	
15. SIGNATURE OF JURY		16. SIGNATURE OF JUDGE	
17. SIGNATURE OF CLERK		18. SIGNATURE OF SHERIFF	
19. SIGNATURE OF DEPUTY SHERIFF		20. SIGNATURE OF JAILER	
21. SIGNATURE OF WARDEN		22. SIGNATURE OF CHIEF OF POLICE	
23. SIGNATURE OF DEPUTY CHIEF OF POLICE		24. SIGNATURE OF SHERIFF	
25. SIGNATURE OF DEPUTY SHERIFF		26. SIGNATURE OF JAILER	
27. SIGNATURE OF WARDEN		28. SIGNATURE OF CHIEF OF POLICE	
29. SIGNATURE OF DEPUTY CHIEF OF POLICE		30. SIGNATURE OF SHERIFF	
31. SIGNATURE OF DEPUTY SHERIFF		32. SIGNATURE OF JAILER	
33. SIGNATURE OF WARDEN		34. SIGNATURE OF CHIEF OF POLICE	
35. SIGNATURE OF DEPUTY CHIEF OF POLICE		36. SIGNATURE OF SHERIFF	
37. SIGNATURE OF DEPUTY SHERIFF		38. SIGNATURE OF JAILER	
39. SIGNATURE OF WARDEN		40. SIGNATURE OF CHIEF OF POLICE	
41. SIGNATURE OF DEPUTY CHIEF OF POLICE		42. SIGNATURE OF SHERIFF	
43. SIGNATURE OF DEPUTY SHERIFF		44. SIGNATURE OF JAILER	
45. SIGNATURE OF WARDEN		46. SIGNATURE OF CHIEF OF POLICE	
47. SIGNATURE OF DEPUTY CHIEF OF POLICE		48. SIGNATURE OF SHERIFF	
49. SIGNATURE OF DEPUTY SHERIFF		50. SIGNATURE OF JAILER	
51. SIGNATURE OF WARDEN		52. SIGNATURE OF CHIEF OF POLICE	
53. SIGNATURE OF DEPUTY CHIEF OF POLICE		54. SIGNATURE OF SHERIFF	
55. SIGNATURE OF DEPUTY SHERIFF		56. SIGNATURE OF JAILER	
57. SIGNATURE OF WARDEN		58. SIGNATURE OF CHIEF OF POLICE	
59. SIGNATURE OF DEPUTY CHIEF OF POLICE		60. SIGNATURE OF SHERIFF	
61. SIGNATURE OF DEPUTY SHERIFF		62. SIGNATURE OF JAILER	
63. SIGNATURE OF WARDEN		64. SIGNATURE OF CHIEF OF POLICE	
65. SIGNATURE OF DEPUTY CHIEF OF POLICE		66. SIGNATURE OF SHERIFF	
67. SIGNATURE OF DEPUTY SHERIFF		68. SIGNATURE OF JAILER	
69. SIGNATURE OF WARDEN		70. SIGNATURE OF CHIEF OF POLICE	
71. SIGNATURE OF DEPUTY CHIEF OF POLICE		72. SIGNATURE OF SHERIFF	
73. SIGNATURE OF DEPUTY SHERIFF		74. SIGNATURE OF JAILER	
75. SIGNATURE OF WARDEN		76. SIGNATURE OF CHIEF OF POLICE	
77. SIGNATURE OF DEPUTY CHIEF OF POLICE		78. SIGNATURE OF SHERIFF	
79. SIGNATURE OF DEPUTY SHERIFF		80. SIGNATURE OF JAILER	
81. SIGNATURE OF WARDEN		82. SIGNATURE OF CHIEF OF POLICE	
83. SIGNATURE OF DEPUTY CHIEF OF POLICE		84. SIGNATURE OF SHERIFF	
85. SIGNATURE OF DEPUTY SHERIFF		86. SIGNATURE OF JAILER	
87. SIGNATURE OF WARDEN		88. SIGNATURE OF CHIEF OF POLICE	
89. SIGNATURE OF DEPUTY CHIEF OF POLICE		90. SIGNATURE OF SHERIFF	
91. SIGNATURE OF DEPUTY SHERIFF		92. SIGNATURE OF JAILER	
93. SIGNATURE OF WARDEN		94. SIGNATURE OF CHIEF OF POLICE	
95. SIGNATURE OF DEPUTY CHIEF OF POLICE		96. SIGNATURE OF SHERIFF	
97. SIGNATURE OF DEPUTY SHERIFF		98. SIGNATURE OF JAILER	
99. SIGNATURE OF WARDEN		100. SIGNATURE OF CHIEF OF POLICE	

CERTIFICATE OF DEATH

Reg. Dist. No.

11657

1. PLACE OF DEATH a. COUNTY MONTGOMERY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 6 DAYS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY MONTGOMERY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BROOKEVILLE		d. STREET ADDRESS X		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL, INC.																	
3. NAME OF DECEASED (Type or print) First THOMAS		Middle ADRIAN		Last RIDGELY		4. DATE OF DEATH Month OCTOBER		Day 19		Year 19 59							
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 2/12/87		9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER - Farmer				10b. KIND OF BUSINESS OR INDUSTRY Agriculture				11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME WILLIAM ADRAIN RIDGELY						14. MOTHER'S MAIDEN NAME MARIE ANTOINETTE OFFUTT											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)				INFORMANT HOSPITAL RECORDS				Address OLNEY, MD.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured Aortic Aneurysm DUE TO (left Common Iliac) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arteriosclerosis DUE TO (c)																INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 10-13 , 19 59 , to 10-19 , 19 59 , that I last saw the deceased alive on 10-14 , 19 59 , and that death occurred at 9:52 PM , from the causes and on the date stated above.																	
ACTUAL SIGNATURE J. Schumacher				ADDRESS (Street, city or town, state) Baithersburg, Md.				DATE SIGNED Oct 10, 1959									
PHYSICIAN'S NAME (Type) J. SCHUMACHER, M. D.				GAITHERSBURG, MARYLAND													
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 10-23-59				22c. NAME OF CEMETERY OR CREMATORY Oak Grove				22d. LOCATION (City, town, or county) (State) Alameda, Howard Co. Md.					
23. FUNERAL DIRECTOR'S SIGNATURE Arthur A. Haight				ADDRESS Hypherville, Md.				24a. REC'D BY REGISTRAR DATE OCT 26 59				24b. REGISTRAR'S SIGNATURE Arthur S. Frank					

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11632

11658

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY, MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA,		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5419 Glenwood Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle TORBERT Last RILEY		4. DATE OF DEATH Month Oct. Day 29, Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 22, 1901
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Berwyn, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Francis Peyton Torbert		14. MOTHER'S MAIDEN NAME Anna Dalrymple	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Husband		Address Same as Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 COLONARY OCCLUSION DUE TO (b) COLONARY THROMBOSIS DUE TO (c) COLONARY ARTERY SCLEROSIS.		INTERVAL BETWEEN ONSET AND DEATH ACUTE. ACUTE. 15+ YRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PRIMARY ARTERIAL HYPERTENSION			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1950 , 19____, to OCT. 29, 1959 , that I last saw the deceased alive on OCT. 16, 1959 , and that death occurred at 11:45 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE James W. Long M.D.		DATE SIGNED October 29, 1959.	
PHYSICIAN'S NAME (Type) James W. Long		1025 CONN. AVE. N.W. WASH. D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-31-59	
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		22d. LOCATION (City, town, or county) (State) Prince George County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY,		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE NOV 2 '59		Arthur S. Kline	

15558

CERTIFICATE OF DEATH

Residence

Life

5119 A. Road Rd.

5119 A. Road Rd.

MARY

FOREST

RILEY

Female, White

Aug. 20, 1911

Residence

One Year

Barry, Maryland

Female, White, Foreign

One Year

William M. Case

None

No

James E. Long

19-21-22, 1st Lincoln

James A. Hargraves, Bethesda, Md.

James E. Long, Baltimore, Md.

11659

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> c. LENGTH OF STAY IN lb <u>2 DAYS</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> d. STREET ADDRESS <u>13409 FLORAL ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JEAN</u> Middle <u>T.</u> Last <u>RITCHIE</u>		4. DATE OF DEATH Month <u>10</u> Day <u>21</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-31-1900</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOV.</u>	11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>unknown</u>	
14. MOTHER'S MAIDEN NAME <u>TANKERSLEY</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>326-14-2733</u>		17. INFORMANT <u>Mr. Nail (daughter)</u> Address <u>Same as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Posterior Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Artery Occlusion</u> DUE TO (c) <u>Coronary Artery Sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>3 days</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Fall, 1957</u> , to <u>21 Oct, 1959</u> , that I last saw the deceased alive on <u>20 Oct, 1959</u> , and that death occurred at <u>12:50 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>11134 Georgia Ave Silver Spring, Md</u> DATE SIGNED <u>21 Oct 1959</u>			
ACTUAL SIGNATURE <u>Merton L. White</u> M.D.		PHYSICIAN'S NAME (Type) <u>MERTON L. WHITE</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/23/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>OCT 23 '59</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>Raymond A. Ziska</u>		24c. REGISTRAR'S SIGNATURE <u>Carlton S. Harris</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
ISM 9/SB

Arthur L. Kane

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11661

CERTIFICATE OF DEATH

11635

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City, Md. R.F.D. 2 13X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>		d. STREET ADDRESS <u>Folly Quarter Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Otto</u> First <u>C.</u> Middle <u>Rost</u> Last		4. DATE OF DEATH Month <u>Oct</u> Day <u>21</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 30 - 1870</u>
9. AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Not available</u>		14. MOTHER'S MAIDEN NAME <u>Not available</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>579-12-3561A</u>	
17. INFORMANT <u>Daughter Mrs. Geo. E. Miller</u>		Address <u>RFD 2 Ellicott City, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac failure</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary artery arteriosclerosis</u> DUE TO (c) <u>20 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 12, 1958</u> to <u>Oct 21, 1959</u> , that I last saw the deceased alive on <u>Oct 19, 1959</u> , and that death occurred at <u>8:34</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles S. Whitaker</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>CLARKSVILLE, MD. 10/21/59</u>	
PHYSICIAN'S NAME (Type) <u>CHARLES S. WHITAKER, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/24/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Witzke Funeral Dir. 4101 Edmondson Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 23 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

CERTIFICATE OF DEATH

11661

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11636

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery 11662 MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE Maryland b. COUNTY Montg.									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9111 River Rd.				d. STREET ADDRESS 9111 River Rd.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Mervin White Middle Rowell Last				4. DATE OF DEATH Month Oct. Day 16 , Year 1959									
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/31/1901		9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manuf. Representative				10b. KIND OF BUSINESS OR INDUSTRY Manufacturing				11. BIRTHPLACE (State or foreign country) Minnesota				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Henry Rowell						14. MOTHER'S MAIDEN NAME Annie E. Marcey							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO.		17. INFORMANT Address Greta Mason Rowell-wife-as 2d							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH 3 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .													
ACTUAL SIGNATURE <i>Frank J. Broschart</i>				EXAMINER'S NAME (Type) Frank J. Broschart				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Oct. 18, 1959 DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation				22b. DATE THEREOF 10/17/59		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory				22d. LOCATION (City, town, or county) (State) Suitland, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey						ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE OCT 19 59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11663 CERTIFICATE OF DEATH

Reg. Dist. No.

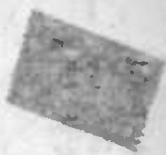
1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 1 month			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1415 CRESTRIDGE DRIVE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) AGNES First GLESSNER Middle RYDER Last RYDER				4. DATE OF DEATH Month October Day 6 Year 1959			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/16/82	
9. AGE (In years last birthday) 77 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MINNESOTA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME FRANK GLESSNER			
14. MOTHER'S MAIDEN NAME MARY E. CROCKER				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. NONE				17. INFORMANT Mr. James D. Kline, 1415 Crestridge Dr.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic malignancy of liver 1538 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Adenocarcinoma of the colon DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 8 months 8 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Hour a. j. _____ p. m. _____ Month _____ Day _____ Year 19			
20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from June , 19 59 , to October , 19 59 , that I last saw the deceased alive on October 5 , 19 59 , and that death occurred at 10:30 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Sydney Leventhal , M.D. 7210 Colesville Rd., Silver Spring, Md.				DATE SIGNED 10/6/59			
PHYSICIAN'S NAME (Type) SYDNEY LEVENTHAL							
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 10/6/59		22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CREMATORY		22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE WERNER E. PUMPHREY, INC. Raymond A. Liska				24a. REC'D BY REGISTRAR DATE OCT 7 '59		24b. REGISTRAR'S SIGNATURE Carlton S. Kline	

TO HOSPITAL OR BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DECEASED'S NAME [Name]		SEX [Male/Female]		AGE [Age]		DATE OF BIRTH [Date]	
PLACE OF BIRTH [Place]		OCCUPATION [Occupation]		MARITAL STATUS [Single/Married/Widowed]		DATE OF DEATH [Date]	
TIME OF DEATH [Time]		PLACE OF DEATH [Place]		CAUSE OF DEATH [Cause]		MANNER OF DEATH [Natural/Unnatural]	
SIGNATURE OF DECEASED [Signature]		SIGNATURE OF WITNESS [Signature]		SIGNATURE OF PHYSICIAN [Signature]		SIGNATURE OF CORONER [Signature]	
NAME OF PHYSICIAN [Name]		NAME OF CORONER [Name]		NAME OF DECEASED'S NEAREST RELATIVE [Name]		NAME OF DECEASED'S NEXT OF KIN [Name]	
ADDRESS OF DECEASED [Address]		ADDRESS OF CORONER [Address]		ADDRESS OF DECEASED'S NEAREST RELATIVE [Address]		ADDRESS OF DECEASED'S NEXT OF KIN [Address]	
CITY OF DECEASED [City]		CITY OF CORONER [City]		CITY OF DECEASED'S NEAREST RELATIVE [City]		CITY OF DECEASED'S NEXT OF KIN [City]	
STATE OF DECEASED [State]		STATE OF CORONER [State]		STATE OF DECEASED'S NEAREST RELATIVE [State]		STATE OF DECEASED'S NEXT OF KIN [State]	
COUNTY OF DECEASED [County]		COUNTY OF CORONER [County]		COUNTY OF DECEASED'S NEAREST RELATIVE [County]		COUNTY OF DECEASED'S NEXT OF KIN [County]	
ZIP CODE OF DECEASED [ZIP]		ZIP CODE OF CORONER [ZIP]		ZIP CODE OF DECEASED'S NEAREST RELATIVE [ZIP]		ZIP CODE OF DECEASED'S NEXT OF KIN [ZIP]	



THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE STATE DEPARTMENT OF HEALTH, BALTIMORE, MD, AND A COPY IS TO BE FURNISHED TO THE LOCAL HEALTH DEPARTMENT, [City], [State].

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11664 Item 7 Film G255 1-27-60 et
CERTIFICATE OF DEATH

11638

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montg.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>AnneArundel</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Rural, 2 Yrs</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>South Pave., Annapolis, Rural 02X-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Marilea Rest Home</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Reuben</u> Middle <u>Salter</u> Last <u>Salter</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>23</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>Unknown</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 28-1883</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>25</u>		11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Cabinet Builder</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>A.G. Salter</u>				14. MOTHER'S MAIDEN NAME <u>Fannie Rawliston</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>579-07-8189</u>		17. INFORMANT <u>Marilea Home Records,</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Disease</u> <u>422.1</u> DUE TO (b) <u>Chronic Myocardial Disease</u> (c) <u>Stenosed Aortic Valve</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 22, 1958</u> to <u>Oct. 23, 1959</u> , that I last saw the deceased alive on <u>Oct. 15, 1959</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John S. Rogers</u> M.D.				ADDRESS (Street, city or town, state) <u>1919 Seminary Rd. Silver Spring, Md.</u>			
PHYSICIAN'S NAME (Type) <u>John S. Rogers</u>				DATE SIGNED <u>Oct 23, 1959</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-27-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner. Gaithersburg, Md.</u>				24a. REC'D BY REGISTRAR <u>OCT 28 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Housh</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hour after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 10-54-1

<p>1. NAME OF DECEASED WILLIAM FREDERICK</p>		<p>2. SEX MALE</p>	
<p>3. AGE 68</p>		<p>4. DATE OF DEATH 10-15-1954</p>	
<p>5. PLACE OF DEATH HOME</p>		<p>6. CITY BALTIMORE</p>	
<p>7. COUNTY BALTIMORE</p>		<p>8. STATE MARYLAND</p>	
<p>9. CAUSE OF DEATH HEART DISEASE</p>			
<p>10. MANNER OF DEATH NATURAL</p>			
<p>11. SIGNATURE OF PHYSICIAN J. H. SMITH</p>			
<p>12. SIGNATURE OF REGISTRAR J. H. SMITH</p>			
<p>13. SIGNATURE OF DECEASED (None)</p>			
<p>14. SIGNATURE OF WITNESSES (None)</p>			
<p>15. SIGNATURE OF DECEASED'S NEAREST RELATIVE (None)</p>			
<p>16. SIGNATURE OF DECEASED'S NEXT OF KIN (None)</p>			
<p>17. SIGNATURE OF DECEASED'S ESTATE (None)</p>			
<p>18. SIGNATURE OF DECEASED'S SURVIVOR (None)</p>			
<p>19. SIGNATURE OF DECEASED'S SURVIVOR (None)</p>			
<p>20. SIGNATURE OF DECEASED'S SURVIVOR (None)</p>			
<p>21. SIGNATURE OF DECEASED'S SURVIVOR (None)</p>			
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<p>99. SIGNATURE OF DECEASED'S SURVIVOR (None)</p>			
<p>100. SIGNATURE OF DECEASED'S SURVIVOR (None)</p>			

11525

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park, c. LENGTH OF STAY IN 1b 17 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium and Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 Takoma Park, d. STREET ADDRESS 6418 Sligo Mill Rd., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Schaffer		4. DATE OF DEATH Month Day Year October 11, 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 10, 1959
9. AGE (In years lost birthday) yrs. 25		10. IF UNDER 1 YEAR Months Days Hours Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME Ramon Samuel Schaffer		14. MOTHER'S MAIDEN NAME Muriel - Wolck	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. no INFORMANT father Address same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 433.0 DUE TO Basal Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Raymond F. Chinn M.D. 925 Pershing Dr., Silver Spring, Md. PHYSICIAN'S NAME (Type) Raymond F. Chinn, M. D. 925 Pershing Dr., Silver Spring, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 10-12-59	22c. NAME OF CEMETERY OR CREMATORY Washington Sanitarium & Hospital, Takoma Park, Md.	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Hare, M. D. Washington Sanitarium and Hospital, Takoma Park 12, Md.		24a. REC'D BY REGISTRAR OCT 20 59 REGISTRAR'S SIGNATURE Arthur S. Hume	

1

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

2075323XV5

CERTIFICATE OF DEATH

11525

1

1

NAME OF DECEASED: James Earl Ray
AGE: 35 YEARS
SEX: Male
DATE OF BIRTH: May 19, 1928
PLACE OF BIRTH: London, England
OCCUPATION: Author
CAUSE OF DEATH: Heart Disease
DATE OF DEATH: May 23, 1968
PLACE OF DEATH: London, England
SIGNATURE OF DECEASED: James Earl Ray
SIGNATURE OF WITNESS: James Earl Ray
SIGNATURE OF PHYSICIAN: James Earl Ray
SIGNATURE OF CLERK: James Earl Ray
SIGNATURE OF JUDGE: James Earl Ray
SIGNATURE OF SHERIFF: James Earl Ray
SIGNATURE OF DISTRICT ATTORNEY: James Earl Ray
SIGNATURE OF PROSECUTOR: James Earl Ray
SIGNATURE OF DEFENSE ATTORNEY: James Earl Ray
SIGNATURE OF JURY: James Earl Ray
SIGNATURE OF COURT: James Earl Ray
SIGNATURE OF JAILER: James Earl Ray
SIGNATURE OF PRISON WARDEN: James Earl Ray
SIGNATURE OF CHIEF OF POLICE: James Earl Ray
SIGNATURE OF MAYOR: James Earl Ray
SIGNATURE OF GOVERNOR: James Earl Ray
SIGNATURE OF PRESIDENT: James Earl Ray

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11665

CERTIFICATE OF DEATH

Reg. Dist. No.

11640

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>26</u> <u>das</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Louise</u> Middle <u>Shheer</u> Last <u>Shheer</u>		4. DATE OF DEATH Month <u>10</u> Day <u>16</u> Year <u>19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/18/17</u>
9. AGE (In years lost birthday) <u>42</u> yrs.		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>28</u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John O'Donnoghue</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Schmitt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Wilmer P. Scheer - Husband - Item #2</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Malnutrition</u> <u>157x</u> DUE TO <u>* electrolyte imbalance</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of the pancreas</u> DUE TO <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>12 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 1</u> , 19 <u>57</u> , to <u>Oct 16</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Oct 16</u> , 19 <u>59</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Horace W. Bernton</u> <u>10511 Summit Ave.</u> <u>10-16-59</u> <u>Kensington, Md.</u>			
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) <u>Horace W. Bernton</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-19-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 20 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>			

1166



CERTIFICATE OF DEATH

1166

Form with multiple lines for text entry, including fields for name, date, and location. The text is faint and mostly illegible due to the quality of the scan. Some visible text includes "Name of Deceased", "Date of Death", and "Place of Death".

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11666

CERTIFICATE OF DEATH

Reg. Dist. No.

11641

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNT Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 26 Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MELANIE Middle DAWN Last SCHNEIDER		4. DATE OF DEATH Month Oct. Day 3 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 3, 1959
9. AGE (In years lost birthday) 5 yrs.		10. IF UNDER 1 YEAR Months 5 Days 5 Hours 5 Min. 5	11. IF UNDER 24 HRS Months 5 Days 5 Hours 5 Min. 5
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) Bethesda, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles William Schneider		14. MOTHER'S MAIDEN NAME Audrey L. Bond	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None	
17. INFORMANT Charles W. Schneider - Item #2-Father		Address Charles W. Schneider - Item #2-Father	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 751X Premature Baby (c Spina) DUE TO (b) Bilateral Meningocele DUE TO (c) (7th mo.) (sent to L.A.B.) Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 5-10 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) 10/3/59 4:30 P.M.	
21. I certify that I attended the deceased from 8/1/59 , 19 59 , to 10/3/59 , 19 59 , that I last saw the deceased alive on 10/3/59 , 19 59 , and that death occurred at 4:30 P.M. M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED 10/3/59	
ACTUAL SIGNATURE Sam Allen		M.D. SAM ALLEN, M.D. Kensington, Maryland	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-5-59	
22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		24a. REC'D BY REGISTRAR OCT 6 '59	
24b. REGISTRAR'S SIGNATURE Arthur J. Kline			

2074221XV0

CERTIFICATE OF DEATH

1968

County	Harford
Township	Harford
City	Harford
Street	Harford
Zip	21050
Age	40
Sex	Male
Marital Status	Married
Occupation	Harford
Education	Harford
Religion	Harford
Signature	Harford
Date	Harford

[Handwritten signature and notes, including "Harford" and "1968"]

[Faint, illegible text at the bottom of the page]

CERTIFICATE OF DEATH

11667

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 4 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Douglas Last Scott		4. DATE OF DEATH Month 10 Day 1 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5.7.84
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Bank Supplies & Equipment	
11. BIRTHPLACE (State or foreign country) Scotland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Kennedy Scott		14. MOTHER'S MAIDEN NAME Mary Ann Duncan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 107-05-6615-4	
17. INFORMANT Address Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) and Tracheobronchitis (c) Carcinoma of Prostate			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/2/59 , 19 59 , to 10/1/59 , 19 59 , that I last saw the deceased alive on 10/1/59 , and that death occurred at 7:10 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE [Signature]		ADDRESS (Street, city or town, state) DATE SIGNED 10/2/59	
PHYSICIAN'S NAME (Type) J. W. Bird, M. D.		Sandy Spring, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	22b. DATE THEREOF 10/2/59	22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory	22d. LOCATION (City, town, or county) (State) Prince Geo. County, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Liska		24a. REC'D BY REGISTRAR OCT 5 1959	
ADDRESS Silver Spring, Md.		24b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>John J. Smith</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>Jan 1, 1880</u></p>		<p>4. Age: <u>37</u></p>	
<p>5. Date of death: <u>Jan 1, 1917</u></p>		<p>6. Time of death: <u>10:00 AM</u></p>	
<p>7. Place of death: <u>Home</u></p>		<p>8. Cause of death: <u>Heart Disease</u></p>	
<p>9. Immediate cause: <u>Myocardial Infarction</u></p>		<p>10. Underlying cause: <u>Arteriosclerosis</u></p>	
<p>11. Contributing cause: <u>None</u></p>		<p>12. Manner of death: <u>Natural</u></p>	
<p>13. Signature of physician: <u>[Signature]</u></p>		<p>14. Signature of registrar: <u>[Signature]</u></p>	
<p>15. Date of registration: <u>Jan 1, 1917</u></p>		<p>16. Place of registration: <u>Boston</u></p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11643

11526

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>8 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. San & Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SEK First <u>Best</u> Middle <u>—</u> Last <u>Seek</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>24</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-20-89</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dairy Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard Seek</u>		14. MOTHER'S MAIDEN NAME <u>Isabelle Cole</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>— None</u>	
17. INFORMANT <u>Chart.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Myocardial rupture</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Chronic Myocardial Infarction, Acute Myocardial Infarction</u> (c) <u>Atherosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary embolism, Chronic Hypertension</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>6:25 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. H. Holohom MD</u> M.D.		ADDRESS (Street, city or town, state) <u>500 Underwood St NW</u> DATE SIGNED <u>10/24/59</u>	
PHYSICIAN'S NAME (Type) <u>Wes H. WOLOHON MD</u>		<u>Wash, DC</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct. 27 59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>George Washington</u>	22d. LOCATION (City, town, or county) (State) <u>Adelphi Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Roy W Barber</u> ADDRESS <u>Saylorville Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 28 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

11443

CERTIFICATE OF DEATH

11443

YARD LINE STATE OF NEW YORK
COUNTY OF ...
CITY OF ...
DECEASED ...
DATE OF DEATH ...
PLACE OF DEATH ...
CAUSE OF DEATH ...
MANNER OF DEATH ...
SIGNATURE OF ...
DATE ...

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11668

CERTIFICATE OF DEATH

Reg. Dist. No.

11644

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kentucky b. COUNTY Crummies			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crummies 55X-3			
c. LENGTH OF STAY IN 1b 16 days				d. STREET ADDRESS No street address			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Childres		First Childres Middle (None) Last Shackleford		4. DATE OF DEATH October 6, 1959		Month October Day 6 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 3, 1904	9. AGE (In years lost birthday) 55 yrs.	IF UNDER 1 YEAR Months 55 Days 55 Hours 55 Min.	IF UNDER 24 HRS. Months 55 Days 55 Hours 55 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mining		11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Shackleford				14. MOTHER'S MAIDEN NAME Lavina Ledford			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 103-10-6656		INFORMANT The Medical Record, Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aortic stenosis DUE TO Rheumatic heart disease, Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) inactive unknown DUE TO (c) inactive unknown				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Transventricular aortic valvulotomy				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from September 20 1959 , to October 6, 1959 , that I last saw the deceased alive on October 6, 1959 , and that death occurred at 12:50 PM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) The Clinical Center				DATE SIGNED 10-6-59			
ACTUAL SIGNATURE Lazar Greenfield				M.D. The Clinical Center			
PHYSICIAN'S NAME (Type) Lazar Greenfield, M.D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 10/7/59		22c. NAME OF CEMETERY OR CREMATORY --		22d. LOCATION (City, town, or county) (State) Crummies, Kentucky	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.-2901 14th St., N.W. Wash. DC				24a. REC'D BY REGISTRAR OCT 8 '59		24b. REGISTRAR'S SIGNATURE Arthur A. Hines	

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11-48

11-48

Kentucky

Kentucky

Orlando

10 days

Orlando

The Clinical Center, Bethesda 11, Md. No street address

59

6

October

Shackelford

(None)

Chinese

52

July 3, 1901

X

White

Male

U. S. A.

Kentucky

Coal Mining

Physic

James LeRoy

William Shackelford

The Medical Record,

102-10-65-6 The Clinical Center, Bethesda 11, Maryland

September 20 59 October 6 59

12:50P

October 6 59

10-6-59

The Clinical Center
National Institutes of Health
Bethesda 11, Maryland

James LeRoy, M.D.

Orlando, Kentucky

10/1/59

The S. A. 10-1-5901 10-1-5901

11669

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 30 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Manassas c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 83X3 d. STREET ADDRESS 438 Stuart Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Ruth Marie SHOEMAKE			4. DATE OF DEATH Month Day Year October 23 19 59				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-8-17	9. AGE (In years last birthday) 42 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) New York			
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME August MICHEL			14. MOTHER'S MAIDEN NAME Anna EYSER				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		INFORMANT Address (Husband) Arthur L Shoemake Same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0 Primary Biliary Cirrhosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 5 yrs.		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 23 Sept. , 19 59 , to 23 October 1959 , that I last saw the deceased alive on 23 October , 19 59 , and that death occurred at 5:50AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED R. G. Muth U.S. Naval Hospital, Bethesda, Md ACTUAL SIGNATURE M.D. 10-23-59 PHYSICIAN'S NAME (Type) R.G. MUTH LT MC USN U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-27-59		22c. NAME OF CEMETERY OR CREMATORY Arlington National			
22d. LOCATION (City, town, or county) (State) Arlington Va.		24a. REC'D BY REGISTRAR OCT 27 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Shoemake			
23. FUNERAL DIRECTOR'S SIGNATURE Baker and Son 314 West Street Manassas, Va							

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11602

Virginia

Montgomery

Virginia

30 days

Testimony (Hearsay)

432 Street, Avenue

U.S. Naval Hospital, Bethesda Md.

SHENANDOAH

Maryland

Admission

11-1-17

Female white

U.S.

New York

None

Housewife

James E. Byrd

August 1917

(Inmate) August 1917, State of Va.

None

No

James E. Byrd

11670

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>6733 Fairfax Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>Davis</u> Last <u>Smith</u>				4. DATE OF DEATH Month <u>10</u> Day <u>15</u> Year <u>1959</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-3-'57</u>		9. AGE (In years last birthday) <u>12 days</u>	IF UNDER 1 YEAR Months <u>12</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Child</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Smith</u>				14. MOTHER'S MAIDEN NAME <u>Barbara Flynn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Father</u>		Address <u>Thomas Smith</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intrapneumonic hemorrhage, defuse, idiopathic</u> <u>763.0</u> DUE TO (b) <u>(Found dead in bed)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>19</u> a. m. <u></u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10-16-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>10/20/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumfrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 19 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

2075302XV5

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

THE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11671

CERTIFICATE OF DEATH

11647

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>STEVEN LAURIE SMITH</u>		4. DATE OF DEATH Month Day Year <u>OCT 7 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 19-1959</u>
9. AGE (In years last birthday) <u>4 1/2</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>COLEMAN SMITH</u>	
14. MOTHER'S MAIDEN NAME <u>ELAINE CRAWFORD</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>none</u>	
16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mr. Coleman Smith, 12005 St. Dunston Rd. Wheaton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>2 Broncho Pneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>1. Asphyxiation.</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>Oct 6</u> , 19 <u>59</u> , to <u>Oct 6</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Oct 6</u> , 19 <u>59</u> , and that death occurred at <u>7:25</u> M, from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Arthur A. Davis</u> M.D.		ADDRESS (Street, city or town, state) <u>8200 16th St., N.W. Washington, D.C.</u>	
PHYSICIAN'S NAME (Type) <u>ARTHUR A. DAVIS</u>		DATE SIGNED <u>10/7/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/8/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. HUMPHREY, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>DATE OCT 8 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur A. Davis</u>			

DR. BROCHART NOTIFIED

1. TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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STATE OF TEXAS
COUNTY OF DALLAS

11/11/11

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11648

Reg. Dist. No.

11672

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>40 min.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Gaithersburg,</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>Warfield Rd. RFD #2</u>			
3. NAME OF DECEASED (Type or print) <u>Warren</u> First <u>Wesley</u> Middle <u>Smith</u> Last				4. DATE OF DEATH Month <u>10</u> Day <u>19</u> Year <u>19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>1/11/01</u>		9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>D.C. Insurer retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NY</u>			
11. BIRTHPLACE (State or foreign country) <u>NY</u>				12. CITIZEN OF WHAT COUNTRY? <u>21-S-E</u>			
13. FATHER'S NAME <u>Warren Smith</u>				14. MOTHER'S MAIDEN NAME <u>Mavis Edwards</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>577-54-1091</u>		17. INFORMANT <u>Hazel Smith (wife)</u> Address <u>Stn 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Brzechart</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED			
EXAMINER'S NAME (Type) <u>FRANK J. Brzechart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10-19-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 23, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>			
22d. LOCATION (City, town, or county) <u>Suitland, Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>F. Gasch's Sons Hyattsville, Md.</u>					
24a. REC'D BY REGISTRAR DATE <u>OCT 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11649

11527

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>	c. LENGTH OF STAY IN 1b <u>20 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>		d. STREET ADDRESS <u>5816 Greentree Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Elizabeth Rose Sperandio</u>		4. DATE OF DEATH Month Day Year <u>Oct. 27 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/24/85</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>0 3</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Patricola</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>William J. Eminhizer</u>		Address <u>SAME AS</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>5 weeks</u> <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October, 1958</u> , to <u>10/27/1959</u> , that I last saw the deceased alive on <u>10/27/1959</u> , and that death occurred at <u>8:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Russell B. Arnold</u>		ADDRESS (Street, city or town, state) <u>8801 Colesville Road, M.D.</u>	
DATE SIGNED <u>10/27/59</u>			
PHYSICIAN'S NAME (Type) <u>Russell B. Arnold M.D. Silver Spring, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/31/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>	22d. LOCATION (City, town, or county) (State) <u>Silver Spring, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>OCT 29 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

File No. 10

1155

PLACE OF DEATH		MARRIAGE	
1. PLACE OF DEATH		2. MARRIAGE	
3. PLACE OF DEATH		4. MARRIAGE	
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19. PLACE OF DEATH		20. MARRIAGE	
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99. PLACE OF DEATH		100. MARRIAGE	

CHIEF CLERK

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11650

11673

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 8 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY Union c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elizabeth d. STREET ADDRESS 18 A Pioneer Home e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Danny Middle Benny Last Stewart			4. DATE OF DEATH Month October Day 12, Year 19 59		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 2, 1948	9. AGE (In years last birthday) 11 yrs.	IF UNDER 1 YEAR Months 11 Days 12, Hours 19 Min. 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) New Jersey	
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME James T. Stewart		
14. MOTHER'S MAIDEN NAME Mary Stewart			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		
16. SOCIAL SECURITY NO. None			INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation 754.5 DUE TO Status, postoperative Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiac Surgery DUE TO (c) Congenital Heart Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Life					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 19	
20f. (City or town) 19		(County) 19		(State) 19	
21. I certify that I attended the deceased from October 4, 1959 to October 12, 1959 , that I last saw the deceased alive on October 12, 1959 , and that death occurred at 8:50 P.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE William W. Pfaff		M.D. The Clinical Center		DATE SIGNED 10/13/59	
PHYSICIAN'S NAME (Type) William W. Pfaff, M.D.		National Institutes of Health		Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-17-59		22c. NAME OF CEMETERY OR CREMATORY ROSEHILL CEMETERY	
22d. LOCATION (City, town, or county) LINDEN UNION NJ		(State) NJ		22e. REGISTRAR'S SIGNATURE Arthur L. Kraus	
23. FUNERAL DIRECTOR'S SIGNATURE B.M. Nesbitt		ADDRESS Elizabeth NJ		DATE OCT 16 '59	

MEDICAL CERTIFICATION

2012

Verzeichnis der Mitglieder

01/10/2001

12012-01-01

Congenital Heart Disease

1000



William H. Hall, M.D.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11535

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11651

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Monty</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>4 hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Board of Education office</u>				d. STREET ADDRESS <u>4501 Furman Ct.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Maie</u> Middle <u>Kessinger</u> Last <u>Stewart</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>6</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-10-1918</u>	
9. AGE (In years last birthday) <u>40</u> yrs.		IF UNDER 1 YEAR Months <u>10</u> Days <u>26</u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seitch</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Board of education</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Walter O. Kessinger</u>				14. MOTHER'S MAIDEN NAME <u>Bertha Kirk</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>Yes</u>		17. INFORMANT <u>Sheridan Stewart - Item #2-Husband</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>Fond dead in bath room</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Brosch</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10-6-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur.-Trans.</u>		22b. DATE THEREOF <u>10-10-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oakwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Mercer County, W. Va.</u>	
23. REGISTRAR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 8 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Thomas</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11652

11674

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>5 1/2 HRS.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>SUBURBAN HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ROGER</u> Middle <u>J</u> Last <u>STICHT</u>		4. DATE OF DEATH Month <u>10</u> Day <u>26</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-30-1922</u>
9. AGE (In years last birthday) <u>37</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ACCOUNT EXECUTIVE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TELEVISION</u>	
11. BIRTHPLACE (State or foreign country) <u>Niagara Falls, N. Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John J. Sticht</u>		14. MOTHER'S MAIDEN NAME <u>Leola Doyle</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes, give war or dates of service) <u>Army</u>		16. SOCIAL SECURITY NO. <u>094-16-4910</u>	
17. INFORMANT <u>Clifford H. Taylor</u>		Address <u>8505 Howell Rd., Beth., Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asystole</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Myocardial Infarction</u> (c) <u>Coronary arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 25</u> , 19 <u>59</u> , to <u>Oct 26</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Oct 30</u> , 19 <u>59</u> , and that death occurred at <u>4 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William Henry Kelly</u>		ADDRESS (Street, city or town, state) <u>9902 Central Rd</u>	
PHYSICIAN'S NAME (Type) <u>William Henry Kelly</u>		DATE SIGNED <u>Belknap H m</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/29/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>Oct 30 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Clifford H. Taylor</u>	

[illegible]

2001

11675

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>27 Maryland Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Rosie</u> Middle <u>Elizabeth</u> Last <u>Talbott</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>15</u> Year <u>19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 26-1869</u>
9. AGE (In years last birthday) <u>90 yrs.</u>		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>19</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home Work</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>John W. Stephens</u>		14. MOTHER'S MAIDEN NAME <u>Sarah E. Ault</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Roy L. Talbott. Gaithersburg, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>10 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1950</u> , to <u>Oct 15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Oct 14</u> , 19 <u>57</u> , and that death occurred at <u>6:15 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8 Russell Ave Gaithersburg Md</u> DATE SIGNED <u>10-16-59</u>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.		PHYSICIAN'S NAME (Type) <u>FRANK J. BROSCHE</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-17-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>	22d. LOCATION (City, town, or county) (State) <u>Beallsville. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner. Gaithersburg. Md.</u>		24a. REC'D BY REGISTRAR <u>OCT 19 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Charles J. Hume</u>

MEDICAL CERTIFICATION

TO HOSPITALS: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2417 SEMINARY ROAD		d. STREET ADDRESS 12417 SEMINARY ROAD	
3. NAME OF DECEASED (Type or print) First Carl Middle Tamorria Last Tamorria		4. DATE OF DEATH Month October Day 28 Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/6/07
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Real Estate	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME IGNATIUS TAMORRIA		14. MOTHER'S MAIDEN NAME AGATE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES WW #2		16. SOCIAL SECURITY NO. 577-05-7260	
17. INFORMANT Mrs. Lena J. Tamorria		Address 2417 Seminary Road Silver Spring, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Sclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 day 5 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 27 Oct , 19 59 , to 28 Oct , 19 59 , that I last saw the deceased alive on 28 Oct , 19 59 , and that death occurred at 1:45 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Merton L. White		ADDRESS (Street, city or town, state) 11134 Georgia Ave, Silver Spring, Md	
PHYSICIAN'S NAME (Type) MERTON L. WHITE		DATE SIGNED 11/13/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 10/30/59	22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY	22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Zuka		24a. REC'D BY REGISTRAR SILVER SPRING, MD. DATE OCT 30 '59	
24b. REGISTRAR'S SIGNATURE Arthur E. Kross			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of this certificate should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11677

11655

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE North Carolina b. COUNTY <input checked="" type="checkbox"/>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 30 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kannapolis 70x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 918 Taylor Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Joe Middle Elmore Last Thomas		4. DATE OF DEATH Month October Day 31 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 30, 1933		9. AGE (In years last birthday) 25 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Public School		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Clyde Thomas				14. MOTHER'S MAIDEN NAME Bess Elmore			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 241-44-1971		INFORMANT The Clinical Center Medical Record Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 288x DUE TO Renal Insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Gouty Nephropathy (c) Chronic Tophaceous Gout							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from October 1 , 19 59 , to October 31 , 19 59 , that I last saw the deceased alive on October 31 , 19 59 , and that death occurred at 4:30 A. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Martin J. Wohl				ADDRESS (Street, city or town, state) The Clinical Center, Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) MARTIN J. WOHL, M.D.				DATE SIGNED 10-31-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/3/59		22c. NAME OF CEMETERY OR CREMATORY Carolina Memorial Cemetery, Kannapolis, Carolina		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert W. Humphrey				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DATE NOV 4 '59	
						24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CENTRAL AIR CO. OF MD.

North Carolina

Kennapolis

918 Taylor Street

Thomas

October 31

November 30, 1955

North Carolina

W. S. A.

W. S. A.

Public School

W. S. A.

W. S. A.

W. S. A.

W. S. A.

W. S. A.

October 31

October 31

October 31

W. S. A.

W. S. A.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11678

CERTIFICATE OF DEATH

11656

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY A.A. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis d. STREET ADDRESS 147 Prince George Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Joseph Armond THOMPSON				4. DATE OF DEATH Month Day Year October 19 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-9-21	
9. AGE (In years last birthday) 38		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		11. BIRTHPLACE (State or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William THOMPSON				14. MOTHER'S MAIDEN NAME Emily ERD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WW II		17. INFORMANT (Wife) LaDeama B Thompson Same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Respiratory Failure 153.8 DUE TO (b) Metastatic Carcinoma to Brain Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) Primary Carcinoma of Colon PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 17 October 1959 to 19 October 1959 that I last saw the deceased alive on 19 October 1959 and that death occurred at 6:38 PM from the causes and on the date stated above.							
ACTUAL SIGNATURE William P. Baker				ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md.			
PHYSICIAN'S NAME (Type) William P. BAKER LT MC USN				DATE SIGNED 10-20-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-23-59		22c. NAME OF CEMETERY OR CREMATORY National Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers				24a. REC'D BY REGISTRAR 1400 Chapin St. N.W. Washington, D.C.		24b. REGISTRAR'S SIGNATURE Oct 23 1959	

1107

Management
Bethesda (Navy)
2 days
Annapolis

U.S. Naval Hospital, Bethesda, Md. 1st Prince George Street

Male
White
Joseph
Almond
THOMPSON
October 19 1955

U.S. Navy
U.S. Government, Florida
U.S.

William Thompson
(Miss) (Address 5 Thompson Lane 44 42)

[Faint, illegible handwritten text]

October 19 1955
October 19 1955

U.S. Naval Hospital, Bethesda, Md.
U.S. Naval Hospital, Bethesda, Md.

October 19 1955
U.S. Naval Hospital, Bethesda, Md.
U.S. Naval Hospital, Bethesda, Md.

11679

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 4½ hours d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Midway Island e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Baby Boy TRYTHALL				4. DATE OF DEATH Month Day Year October 3 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-2-59	
9. AGE (In years lost birthday) yrs. 1		IF UNDER 1 YEAR Months Days Hours Min. 1		IF UNDER 24 HRS. 1			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Donald L. TRYTHALL				14. MOTHER'S MAIDEN NAME Rita M DEPPENS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		INFORMANT Address (Father) Donald L Trythall Same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Trachea-esophageal Fistula 756.2 Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) and Prematurity DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 40 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3 October, 19 59 to 3 October, 19 59 that I last saw the deceased alive on 3 October, 19 59 , and that death occurred at 11:55 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda Md. 10-5-59							
ACTUAL SIGNATURE H. L. Walton		M.D. U.S. Naval Hospital, Bethesda Md.					
PHYSICIAN'S NAME (Type) H. L. WALTON LT MC USN		U.S. Naval Hospital, Bethesda Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-8-59		22c. NAME OF CEMETERY OR CREMATORY Laureldale		22d. LOCATION (City, town, or county) (State) Laureldale Penn.	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey				ADDRESS 7557 Wisconsin Ave. Bethesda Md.		24a. REC'D BY REGISTRAR 7 '59	
				24b. REGISTRAR'S SIGNATURE Arthur E. Kline			

051

1

2

11072

U.S. NAVAL HOSPITAL, PENSACOLA, FL.

Virginia

Montgomery

Booths (Rural)

by house

Midway Island

U.S. Naval Hospital, Pensacola, FL.

Goodman

RYTHALL

Boy

Boy

10-2-32

White

Male

U.S.

Virginia

None

None

Miss M. DEBBERS

Donald R. RYTHALL

(Father) Donald R. RYTHALL same as 10

None

No

Trunk was signed by father
at Pensacola

U.S. Naval Hospital, Pensacola, FL.

11-25-32

22

3. Carson

U.S. Naval Hospital, Pensacola, FL.

U.S. Naval Hospital, Pensacola, FL.

U.S. Naval Hospital, Pensacola, FL.

U.S. Naval Hospital, Pensacola, FL.

U.S. Naval Hospital, Pensacola, FL.

U.S. Naval Hospital, Pensacola, FL.

11680

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b 18 YRS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4612 CHELTENHAM DRIVE				d. STREET ADDRESS 4612 CHELTENHAM DRIVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LOUIS Middle JOSEPH Last URCIOLO				4. DATE OF DEATH Month 10 Day 31 Year 1959			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 25, 1913	9. AGE (In years last birthday) yrs. 46	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PUBLIC ACCOUNTANT			10b. KIND OF BUSINESS OR INDUSTRY WASHINGTON, D.C.		11. BIRTHPLACE (State or foreign country) USA		
13. FATHER'S NAME ANGELO URICIOLO				14. MOTHER'S MAIDEN NAME ANTONETTE FISCHERIA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. WWTI 577-10-2099		INFORMANT Address 4612 CHELTENHAM DR., BETHESDA.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443 X ACUTE PULMONARY EDEMA DUE TO (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO (c) 20 YEARS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 1 W	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PEPTIC ULCER						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from AUG. , 19 46 , to OCT 31 , 19 59 , that I last saw the deceased alive on OCT 27 , 19 59 , and that death occurred at 6:15 A.M. , from the causes and on the date stated above. ACTUAL SIGNATURE Robert h. Coale M.D. 4630 Montgomery Ave., Bethesda Md DATE SIGNED 10/31/59 PHYSICIAN'S NAME (Type) ROBERT N. COALE MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/3/59		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Fort Meyer Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Frank Geiers Sons Co 3605-14th NW				24a. REC'D BY REGISTRAR DATE NOV 2 '59		24b. REGISTRAR'S SIGNATURE C. L. S. Kraus	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11280

1. Name of deceased: JOHN J. SMITH

2. Sex: Male

3. Age: 45

4. Date of birth: 1905

5. Place of birth: New York City

6. Date of death: 1950

7. Place of death: New York City

8. Cause of death: Heart Disease

9. Duration of illness: 2 weeks

10. Name of attending physician: Dr. J. H. Jones

11. Name of medical examiner: Dr. A. B. Smith

12. Name of funeral home: None

13. Name of next of kin: John J. Smith, Jr.

14. Address of next of kin: 123 Main St., New York City

15. Signature of medical examiner: [Signature]

16. Signature of funeral home: [Signature]

17. Signature of next of kin: [Signature]

18. Date of filing: 1950

19. File number: 11280

11681

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE _____ b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Newington, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3220 Chestnut St NW</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Newington Garden Santorum Wash., D.C.</u>				d. STREET ADDRESS <u>47X-3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>VAGNONI</u> First <u>ROSA</u> Middle <u>M.</u> Last <u>VAGNONI</u>				4. DATE OF DEATH Month <u>OCT</u> Day <u>24</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR 28-1894</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OWNER OF → RESTAURANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ITALY</u>		11. BIRTHPLACE (State or foreign country) <u>US</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>LORENZO CAPONE</u>				14. MOTHER'S MAIDEN NAME <u>CATERINA LE DONNE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. _____		INFORMANT <u>Luigi A. Vagnoni</u> Address <u>7230 West Park Hyattsville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Infarct</u> 334X DUE TO <u>Cerebrovascular Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> (c) <u>diabetes</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>FRACTURE RT. Hip - old</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19__				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at <u>12:45</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edwin P. Parker</u> M.D.				ADDRESS (Street, city or town, state) <u>2015 18th St NW, Wash DC</u> DATE SIGNED <u>10-24-59</u>			
PHYSICIAN'S NAME (Type) <u>EDWIN P. PARKER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-27-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Deaf Freeman Home</u> ADDRESS <u>4812 Galois Rd DC.</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 27 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. King</u>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CENTRAL AVE. ORIGIN

1987

K

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11660

11528

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>1 hr-20 min</u>		d. STREET ADDRESS <u>1228 Blair Mill Rd</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>(V.M.)</u> Last <u>Valltos</u>		4. DATE OF DEATH Month <u>10</u> Day <u>1</u> Year <u>1959</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-3-94</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Greece</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Steven Kabetain</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute coronary thrombosis</u> DUE TO (c) <u>Diabetes mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u> <u>6 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/30</u> , 19 <u>59</u> , to <u>10/1</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10/1</u> , 19 <u>59</u> , and that death occurred at <u>12:30</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bennet A. Porter, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>9301 Colesville Rd, Silver Spring, Md.</u> DATE SIGNED <u>Oct. 1, 59</u>	
PHYSICIAN'S NAME (Type) <u>Bennet A. Porter, Jr., M.D.</u>		<u>9301 Colesville Rd, Silver Spring, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 3, 59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Calver Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Calver Hill</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.C. Thompson & Son</u>		ADDRESS <u>5732</u>	
24a. REC'D BY REGISTRAR DATE <u>OCT 5 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton E. Jones</u>	

CERTIFICATE OF DEATH

1882

STATE OF NEW YORK

1880

[Faint, mostly illegible text follows, likely containing details of the death certificate such as name, date, and cause of death.]

11682

CERTIFICATE OF DEATH

Reg. Dist. No.

11661

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Ohio b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 28 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Warren 72 x - 3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.			d. STREET ADDRESS 427 Central Parkway, S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ALVIN Middle CARL Last VICK			4. DATE OF DEATH Month October Day 31 Year 1959		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 February 1900		9. AGE (In years last birthday) 59 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Steel		11. BIRTHPLACE (State or foreign country) Ohio	
12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME Henry C. Vick			14. MOTHER'S MAIDEN NAME Ida Lebowsky		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) unavailable		INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adrenal Cortical Carcinoma with Metastasis 1950 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 3 Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. October 31 1959		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 31 1959 to October 31 1959 , that I last saw the deceased alive on October 31 1959 , and that death occurred at 9:24 a.m. from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>Howard S. Schwartz</i>		ADDRESS (Street, city or town, state) The Clinical Center 10-31-59 National Institutes of Health Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) HOWARD S. SCHWARTZ, M.D.		DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit 11/4/59		22b. DATE THEREOF 11/4/59		22c. NAME OF CEMETERY OR CREMATORY Crown Hill Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		22d. LOCATION (City, town, or county) (State) Vienna, Ohio	
24a. REC'D BY REGISTRAR DATE NOV 4 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur B. Kline</i>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11082

11082

ALVIN CARL VICK
October 31, 1959
U.S.A.
The Clinical Center, Bethesda, Md.
National Institutes of Health
Howard S. Schwartz, M.D.
October 31, 1959
U.S.A.
The Clinical Center, Bethesda, Md.
National Institutes of Health
Howard S. Schwartz, M.D.

October 31, 1959
U.S.A.
The Clinical Center, Bethesda, Md.
National Institutes of Health
Howard S. Schwartz, M.D.
October 31, 1959
U.S.A.
The Clinical Center, Bethesda, Md.
National Institutes of Health
Howard S. Schwartz, M.D.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11683

CERTIFICATE OF DEATH

11662
Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 11 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47 X - 3		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.			d. STREET ADDRESS 1605 "D" Street N.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Joseph Middle Frank Last WAGNER			4. DATE OF DEATH Month October Day 9 Year 19 59		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-19-98		9. AGE (In years last birthday) 61 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Joseph Wagner			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. INFORMANT		Address (Son) Joseph F. Wagner Jr. Clinton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cornary artery disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I attended the deceased from 28 Sept , 19 59 , to 9 October , 19 59 , that I last saw the deceased alive on 9 October , 19 59 , and that death occurred at 9:30 PM from the causes and on the date stated above.					
ACTUAL SIGNATURE Bruce H Ricci		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md.		DATE SIGNED 10-10-59	
PHYSICIAN'S NAME (Type) B.H. RICE LT MC USN		U.S. Naval Hospital, Bethesda Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-14-59	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Arlington Virginia		
23. FUNERAL DIRECTOR'S SIGNATURE LEE 4th and Massachusetts Ave. N.W. Washington D.C.		24a. REC'D BY REGISTRAR 16 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11785
212

CERTIFICATE OF BIRTH

11623

Placed at Columbia

Washington

at day

Rebecca (Mabel)

1005 "D" Street N.E.

U.S. Naval Hospital, Bethesda Md.

WAGNER

WAGNER

Joseph

October 2

61

5-10-08

White

Male

U.S.

New York

U.S. Government

U.S. Navy

Unknown

Joseph Wagner

(Son) Joseph E. Wagner Jr. Clinton, Md.

WW II

Yes

Acute myocardial infarction

Coronary artery disease

October 2

22 Sept

22

October

U.S. Naval Hospital, Bethesda Md.

10-10-59

U.S. Naval Hospital, Bethesda Md.

U.S. NAVY

Arlington National

Washington National

10-10-59

1005 "D" Street N.E. Washington D.C.

11684
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 11684
 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 10 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis d. STREET ADDRESS 219 Fig Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last Richard Leon WALCOTT				4. DATE OF DEATH Month Day Year October 15 1959				
5. SEX male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-2-50		
9. AGE (In years last birthday) yrs. 9		10. IF UNDER 1 YEAR Months Days Hours Min. 9		11. IF UNDER 24 HRS. Months Days Hours Min. 9		12. CITIZEN OF WHAT COUNTRY? U.S.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Pennsylvania		
13. FATHER'S NAME William T. WALCOTT				14. MOTHER'S NAME Ida M. MILLER				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		INFORMANT Address (Father) William T. Walcott Same as #2				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 754.0 Congenital heart disease (Tetralogy of Fallot with atrial septal defect) post surgical correction DUE TO (b) status DUE TO (c) status PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 754.0							INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5 October, 1959 , to 15 October, 1959 that I last saw the deceased alive on 15 October, 1959 , and that death occurred at 1:36 PM , from the causes and on the date stated above.								
ACTUAL SIGNATURE James E. McClenathan				ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda Md. 10-16-59				
PHYSICIAN'S NAME (Type) J.E. MC CLENATHEN CDR MC USN				U.S. Naval Hospital, Bethesda Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-18-59		22c. NAME OF CEMETERY OR CREMATORY St. Pauls Lutheran Church		22d. LOCATION (City, town, or county) (State) Stover Missouri		
23. FUNERAL DIRECTOR'S SIGNATURE Robert P. Humphrey				24a. REC'D BY REGISTRAR 19 59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas		
R.A. Pumphrey 7557 Wisconsin Ave. Bethesda Md.								

Montgomery

Boysen (Mrs.)

10 days

U.S. Naval Hospital, Bethesda Md. 210 1st Street

Leon Wilson

Boysen

2-2-30

White

Male

None

None

John M. Miller

William T. Walcott

(Rather) William T. Walcott Same as

None

No

U.S. Naval Hospital, Bethesda Md. 210 1st Street

October 25 1930

October 25

U.S. Naval Hospital, Bethesda Md.

U.S. Naval Hospital, Bethesda Md.

October 25 1930

U.S. Naval Hospital, Bethesda Md.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11685

CERTIFICATE OF DEATH

11664

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Maryland</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Maryland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>3 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Horatio</u> First <u>Wales</u> Middle Last		4. DATE OF DEATH <u>10</u> Month <u>17</u> Day <u>1959</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-12-94</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>3</u>	11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chemist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't</u>	
11. BIRTHPLACE (State or foreign country) <u>Western Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Horatio Wales</u>		14. MOTHER'S MAIDEN NAME <u>Emma Spear</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Merle M Wales</u> Address <u>Bethesda, Md. 4621 N. Chelsea Lane</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism, bilateral</u> <u>465x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>Oct 17 1959</u> Hour a. m. <u>3:30</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>14 Oct</u> , 19 <u>59</u> , to <u>10/17</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10/16</u> , 19 <u>59</u> , and that death occurred at <u>5:25 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. P. Dorman</u>		ADDRESS (Street, city or town, state) <u>1302 18th St NW</u> DATE SIGNED <u>10/17/59</u>	
PHYSICIAN'S NAME (Type) <u>H. P. Dorman</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/19/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>OCT 20 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

CERTIFICATE OF DEATH

11883

STATE OF NEW YORK

11883

On this day of the year 1900, at the County of New York, State of New York, I, the undersigned, a duly qualified and authorized officer, do hereby certify that the within and foregoing is a true and correct copy of the original record of the death of the person named therein, as the same appears from the records of the Department of Health, State of New York, and that the same is a true and correct copy of the original record of the death of the person named therein, as the same appears from the records of the Department of Health, State of New York.

Witness my hand and the seal of the Department of Health, State of New York, at Albany, New York, this day of the year 1900.

Commissioner of Health, State of New York

11686

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Pennsylvania			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 215 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Thomas Middle Edward Last Walsh				4. DATE OF DEATH Month October Day 10 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 23, 1905	
9. AGE (In years lost birthday) 54 yrs.		IF UNDER 1 YEAR Months 54 Days 54 Hours 54 Min.		IF UNDER 24 HRS. Months 54 Days 54 Hours 54 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard				10b. KIND OF BUSINESS OR INDUSTRY Penitentiary		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Thomas M. Walsh				14. MOTHER'S MAIDEN NAME Ellen Ruane			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWII				16. SOCIAL SECURITY NO. 205-10-5636			
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Empyema, right lung and pleura DUE TO Lymphosarcoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Lymphosarcoma (c) Lymphosarcoma INTERVAL BETWEEN ONSET AND DEATH 2 mos. 14 mos.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from March 9 , 19 59 , to October 10 , 19 59 , that I last saw the deceased alive on October 10 , 19 59 , and that death occurred at 6:50a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 10-10-59							
ACTUAL SIGNATURE Jerry S. Trier M.D. The Clinical Center NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
PHYSICIAN'S NAME (Type) Jerry S. Trier, M.D.							
22a. BURIAL, CREMATION, or other disposition Burial-transit 22b. DATE THEREOF 10-11-59 22c. NAME OF CEMETERY OR CREMATORY Cathedral Cemetery 22d. LOCATION (City, town, or county) (State) Scranton, Penna.							
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY ADDRESS Bethesda, Md. 24a. REC'D BY REGISTRAR OCT 14 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4

VS A15 (4)
15M 9/58

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

Abstract

2005 年 12 月 15 日

1914 November 28th Fri

Notes

October

7096 ES 10000

[illegible]

10-10-70

2000-2001

PROCESSED, 1977

• G.N. • 1927 • 3 y. 10h

CERTIFICATE OF DEATH

Reg. Dist. No.

11666

11687

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10014 Sinnott Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GLADYS Middle MARY Last WEISS		4. DATE OF DEATH Month October Day 7 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/5/1898
9. AGE (In years lost birthday) 61 yrs.		10. IF UNDER 1 YEAR Months 61 Days 0 Hours 0 Min. 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk-typist		10b. KIND OF BUSINESS OR INDUSTRY U. S. Govt.	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Charles C. Cook		14. MOTHER'S MAIDEN NAME Josephine L. Hanfmann	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Yes	
17. INFORMANT George B. Weiss-Husband-same as 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) 4 YRS		INTERVAL BETWEEN ONSET AND DEATH INSTANT	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from SEPT , 19 55 , to OCT , 19 59 , that I last saw the deceased alive on Oct 5 , 19 59 , and that death occurred at 5 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Leo E Donovan		ADDRESS (Street, city or town, state) DATE SIGNED 10/8/59	
PHYSICIAN'S NAME (Type) Leo E Donovan		Bethesda 14 MO	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/12/59	22c. NAME OF CEMETERY OR CREMATORY Arlington Cemetery	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR OCT 13 59		24b. REGISTRAR'S SIGNATURE Arthur J. Hanks	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1235

1992-1993

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11667

11688

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>P.O. Box 349</u>			
3. NAME OF DECEASED (Type or print) First <u>Beulah</u> Middle <u>V.</u> Last <u>Welch</u>				4. DATE OF DEATH Month <u>10</u> Day <u>28</u> Year <u>19 59</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>3/24/04</u>		9. AGE (In years last birthday) <u>55</u> yrs.		10. UNDER 1 YEAR IF UNDER 1 YEAR Months <u> </u> Days <u> </u>			
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. KIND OF BUSINESS OR INDUSTRY <u> </u>		13. BIRTHPLACE (State or foreign country) <u>Va.</u>			
14. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>		15. FATHER'S NAME <u>E. Hicks</u>					
16. MOTHER'S MAIDEN NAME <u>Bessie Musser</u>				17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
18. SOCIAL SECURITY NO. <u> </u>				19. INFORMANT <u>Son Gale Welch</u> Address <u>Same</u>			
20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular collapse</u> <u>9030</u> DUE TO <u>Irreversible shock</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>15 minutes</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Status: Operative procedure - brought to postural left hip</u> 21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Fell on Kitchen Floor</u> 22. TIME OF INJURY Month, Day, Year <u>10-23-59</u> 23. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 24. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> 25. (City or town) <u>Gaithersburg</u> (County) <u>Montgomery</u> (State) <u>MD</u>							
26. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Brunsch</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Brunsch</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10-29-59</u>				DATE SIGNED			
27. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		28. DATE THEREOF <u>10-31-59</u>		29. NAME OF CEMETERY OR CREMATORY <u>Groseclose Methodist</u>			
30. LOCATION (City, town, or county) <u>Gaithersburg</u>		(State) <u>Va</u>					
31. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner. Gaithersburg. Md.</u>				32. REC'D BY REGISTRAR <u>NOV 2 '59</u>			
33. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>				34. DATE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11529

CERTIFICATE OF DEATH

Reg. Dist. No.

11668

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>N.Y.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			c. LENGTH OF STAY IN 1b <u>4 wks.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New York 25. 69th St.</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sen & Hosp</u>				d. STREET ADDRESS <u>apt 36 - 4th 92nd St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>(M)</u> Last <u>White</u>				4. DATE OF DEATH Month <u>10</u> Day <u>11</u> Year <u>1959</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>cauc</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/15/197</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife - RN.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>NY MCL</u>	
13. FATHER'S NAME <u>Scharf Thomas</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Wagner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u> </u>		INFORMANT <u>Hosp Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>199.2</u> <u>Symbolism</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) <u>Carcinomatous - peritoneum</u> DUE TO (c) <u>Colon</u>				INTERVAL BETWEEN ONSET AND DEATH <u>terminal</u> <u>six mos</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				(County) <u> </u> (State) <u> </u>			
21. I certify that I attended the deceased from <u>9/13</u> , 19 <u>59</u> , to <u>10/11</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10/11</u> , 19 <u>59</u> , and that death occurred at <u>2:53 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert A. Hare</u>				ADDRESS (Street, city or town, state) <u>Takoma Park, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Robert A. Hare, M.D.</u>				DATE SIGNED <u>10/11/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 13, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT OLIVET CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, BALTO Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Hare</u>				ADDRESS <u>254 Carroll St NW, WASH D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 13 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hare</u>				24c. REGISTRAR'S SIGNATURE <u>Arthur S. Hare</u>			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

11530

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>				c. LENGTH OF STAY IN 1b <i>19 hrs</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington San'y Hosp</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Murtie</i> Middle <i>Alice</i> Last <i>white</i>				4. DATE OF DEATH Month <i>10</i> - Day <i>2</i> - Year <i>1959</i>			
5. SEX <i>Fe</i>		6. COLOR OR RACE <i>Cauc</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>6-21-1875</i>	
9. AGE (In years lost birthday) <i>84 yrs.</i>		IF UNDER 1 YEAR Months <i>84</i> Days <i>ys.</i>		IF UNDER 24 HRS. Hours <i>ys.</i> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Hswf.</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Iowa</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>							
13. FATHER'S NAME <i>Albert Buxton</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>Hosp Records</i>		INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ant. Coronary Infarct</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <i>Arteriosclerosis</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>Oct 1</i> , 1959, to <i>Oct 2</i> , 1959, that I last saw the deceased alive on <i>Oct 2</i> , 1959, and that death occurred at <i>8:05 AM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Robert A. Hare</i>				ADDRESS (Street, city or town, state) <i>7600 Carroll Ave, Tak PK, Md.</i> DATE SIGNED <i>10/2/59</i>			
PHYSICIAN'S NAME (Type) <i>Robert A. Hare</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<i>Buried</i>		<i>Oct 6-1959</i>		<i>Mt. View</i>		<i>Boulder, Colo.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Arthur Walters</i> ADDRESS <i>254 Carroll St NW. D.C.</i>				24a. REC'D BY REGISTRAR DATE <i>OCT 6 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur J. Hare</i>	

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TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

11230

WEST VIRGINIA

DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

1. Name of deceased: _____
2. Sex: _____
3. Age: _____
4. Date of birth: _____
5. Place of birth: _____
6. Date of death: _____
7. Place of death: _____
8. Cause of death: _____
9. Signature of physician: _____
10. Signature of registrar: _____
11. Date of registration: _____

11-10-53

11-10-53

Montgomery

Montgomery

Overnight

4 days

Rebecca

(No exact address)

The Clinical Center, Bethesda II, Md.

St.

October

William

Ann

Elizabeth

in

19 October 1953

White

Female

U. S. A.

Chicago

Home

Hospital

Vivian Powell

Helen Brown

The Medical Record

University of Maryland, The Clinical Center, Bethesda II, Maryland

3 days

Homemade into abdominal cavity

30 hours

Amia

2 to 3 months

Metastatic to thoracic cavity

October 20, 1953

October 20, 1953

October 21, 1953

10-21-53

The Clinical Center

National Institutes of Health

Bethesda II, Maryland

JOHN I. HILL, JR., M.D.

10-21-53

10-21-53

10-21-53

11690

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY 48X-3			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY IN 1b 109 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jacksonville		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.				d. STREET ADDRESS 4741 Godwin Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frederic Middle George Last WILLIAMS				4. DATE OF DEATH Month October Day 29 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-11-19	
9. AGE (In years lost birthday) 40 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy				10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) Ohio	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME William WILLIAMS				14. MOTHER'S MAIDEN NAME Edith LINDSEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW II			
17. INFORMANT (Wife) Margaret Williams				Address Same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Meningioma, intracranial 223X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 3 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12 July , 19 59 , to 29 October , 19 59 , that I last saw the deceased alive on 29 October , 19 59 , and that death occurred at 12:45 PM from the causes and on the date stated above.							
ACTUAL SIGNATURE Adam T. Thorp, Jr.				ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda Md. 10-30-59			
PHYSICIAN'S NAME (Type) Adam T. THORP, Jr., LT, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-1-59		22c. NAME OF CEMETERY OR CREMATORY Clay Cemetery		22d. LOCATION (City, town, or county) (State) Clay Center Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers				24a. REC'D BY REGISTRAR NOV 3 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Rouse	

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Page 4

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO BURIAL, CREMATION, REMOVAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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11691

CERTIFICATE OF DEATH

Reg. Dist. No 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 19 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Quantico d. STREET ADDRESS 210 Broadway Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Gar Middle Angus Last WINGFIELD		4. DATE OF DEATH Month October Day 21 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-14-10
9. AGE (In years last birthday) 49		10. IF UNDER 1 YEAR Months 49 Days 49 Hours 49 Min. 49	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Marine Corps		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Frederick WINGFIELD		14. MOTHER'S MAIDEN NAME Ella WYATT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO. 228 05 1141	
INFORMANT (Wife) Minnie E. WINGFIELD		Address Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Lung with extensive metastases DUE TO (b) metastases DUE TO (c) metastases Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. 163X 2 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 yrs			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2 October, 19 59 to 21 October 19 59 , that I last saw the deceased alive on 21 October, 19 59 , and that death occurred at 11:20PM . I am the causes and on the date stated above.			
ACTUAL SIGNATURE John C. Clenathan		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md.	
PHYSICIAN'S NAME (Type) J. E. MC CLENATHEN CDR MC USN		DATE SIGNED 10-21-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-26-59	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) Arlington Virginia
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey		24a. REC'D BY REGISTRAR OCT 27 59	24b. REGISTRAR'S SIGNATURE Arthur S. Kneass

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

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U.S. Naval Hospital, Bethesda, Md. 210 Broadway Street

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U.S. Marine Corps - U.S. Government - West Virginia

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U.S. Naval Hospital, Bethesda, Md. 210 Broadway Street

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U.S. Naval Hospital, Bethesda, Md.

U.S. Naval Hospital, Bethesda, Md.

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U.S. Naval Hospital, Bethesda, Md.

11531

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PACOMA PATRIC</u>		c. LENGTH OF STAY IN 1b <u>2 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>		e. STREET ADDRESS <u>8607 CARROLL AVE</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FREEDA SARAH Wolf</u>		4. DATE OF DEATH Month <u>10</u> Day <u>20</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>IN</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-1-13</u>
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HSWF</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PA.</u>	
11. BIRTHPLACE (State or foreign country) <u>PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>SAMUEL DIAMOND</u>		14. MOTHER'S MAIDEN NAME <u>SARAH SILVER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-52-7858</u>	
17. INFORMANT <u>PATIENTS HOSP. RECORD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of the breast</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-19-57</u> , 19 <u>—</u> , to <u>October 20, 1959</u> , that I last saw the deceased alive on <u>October 20, 1959</u> , and that death occurred at <u>6:10 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Boris Rabkin</u> M.D.		ADDRESS (Street, city or town, state) <u>1019 University Boulevard Silver Spring Maryland</u>	
DATE SIGNED <u>10/20/59</u>			
PHYSICIAN'S NAME (Type) <u>BORIS RABKIN</u>		<u>Silver Spring Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/21-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glen Shalom Memorial Wash.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg</u> ADDRESS <u>427-928 NW</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 22 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hana</u>	

MEDICAL CERTIFICATION

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11692

CERTIFICATE OF DEATH

11675

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>District of Columbia</i> b. COUNTY <i>Washington</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>	
c. LENGTH OF STAY IN 1b <i>3 months</i>		47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Congressional Manor San.</i>		d. STREET ADDRESS <i>1702 Kilbourne St.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		N.W.	
3. NAME OF DECEASED (Type or print) First <i>Sparrel</i> Middle <i>A.</i> Last <i>Wood</i>		4. DATE OF DEATH Month <i>10</i> Day <i>2</i> Year <i>1959</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10/30/1873</i>
9. AGE (In years last birthday) <i>85</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Teacher</i>	11. BIRTHPLACE (State or foreign country) <i>Virginia</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Richard Johnston Wood</i>	
14. MOTHER'S MAIDEN NAME <i>Judith Shortt</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>	
16. SOCIAL SECURITY NO. <i>none</i>		INFORMANT <i>Cong. Manor Sanitarium Records</i>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i> 331X DUE TO (b) <i>Atherosclerosis</i> DUE TO (c) <i>Port operative Suprapubic prostatectomy BPH</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 hours</i> <i>10 yrs</i>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Port operative Suprapubic prostatectomy BPH</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
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21. I certify that I attended the deceased from <i>May 5</i> , 19 <i>57</i> , to <i>Oct 2</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>Oct 2</i> , 19 <i>59</i> , and that death occurred at <i>11:30 P.M.</i> from the causes and on the date stated above.	
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ACTUAL SIGNATURE <i>William D Oldham</i> M.D.	ADDRESS (Street, city or town, state) <i>915 - 19th St NW</i>	DATE SIGNED <i>Oct 3, 1959</i>
PHYSICIAN'S NAME (Type) <i>William D Oldham MD</i>	<i>915 19th St NW</i>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>10/5/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Washington Nat'l</i>	22d. LOCATION (City, town, or county) (State) <i>Prince Georges Co., Maryland</i>
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23. FUNERAL DIRECTOR'S SIGNATURE <i>The S.A. Brown Co.</i>	24a. REC'D BY REGISTRAR <i>2901 1/2 St. N.W. Wash, D.C.</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knappe</i>
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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11893

CENTRAL OF CLARK

ONE HUNDRED EIGHTY TWO

RECEIVED
JAN 10 1893

For the year ending Dec 31 1892

1892-1893
1893-1894

1893-1894
1894-1895

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11673

11693

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Great Falls</u> c. LENGTH OF STAY IN 1b _____ d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Potomac River</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Van</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u> 831-3 ✓ d. STREET ADDRESS <u>1412 N. Hartford St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>James A. Woodbury</u> First Middle Last 5. SEX <u>male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>4-13-27</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		4. DATE OF DEATH <u>10-24-1959</u> Month Day Year 9. AGE (In years last birthday) <u>32</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 4 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gov. employee</u> 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (State or foreign country) <u>S. Dakota</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>Wallace C Woodbury</u> 14. MOTHER'S MAIDEN NAME <u>Inga Skavang</u> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>WW II</u> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. _____ 17. INFORMANT <u>Wendell Woodbury</u> Address <u>417 8th St.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation by drowning</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Reported to have planned suicide by jumping in Potomac R.</u> 20c. TIME OF INJURY Month, Day, Year <u>10-24-1959</u> Hour <u>2:30</u> p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Potomac R.</u> (City or town) <u>Great Falls</u> (County) <u>Montg</u> (State) <u>MD</u>		21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checkbox"="" checked="" type="checkbox/>, and in my opinion death resulted from: Natural causes <input type="/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> 			
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D. EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>11-7-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> 22b. DATE THEREOF <u>11-7-59</u> 22c. NAME OF CEMETERY OR CREMATORY <u>H. Lincoln</u> 22d. LOCATION (City, town, or county) <u>Prince George Co., Md.</u> (State) _____		24a. REC'D BY REGISTRAR <u>Nov 9 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute in duplicate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11-688

STATE
NEARLY DEPT.

PLACE OF DEATH
11-688

DATE OF DEATH

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